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ABSTRACT

A proposal up for consideration before the United States Senate is discussed. The program suggested is a redesign of the Department of Health, Education, and Welfare in keeping with the principles of the New Federalism. The proposal touches every major area of HEW policy: it simplifies the Department's program structure; it narrows and focuses the Federal role; and it decentralizes decision-making power to individuals, States, and local governments. New initiatives are proposed in: health insurance, student aid, welfare reform, special revenue sharing, and consolidated programs of capacity-building to aid State, local and voluntary service suppliers. (Author/CK)

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# CASPAR W. WEINBERGER TO BE SECRETARY OF HEALTH, EDUCATION, AND WELFARE

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## HEARINGS BEFORE THE COMMITTEE ON LABOR AND PUBLIC WELFARE UNITED STATES SENATE NINETY-THIRD CONGRESS

FIRST SESSION

ON

CASPAR W. WEINBERGER TO BE SECRETARY OF HEALTH,  
EDUCATION, AND WELFARE—ADDITIONAL CONSIDERATION  
BY COMMITTEE ON LABOR AND PUBLIC WELFARE

### PART 2

### APPENDIX

Comprehensive HEW Simplification and Reform  
“MEGA Proposal”

Printed for the use of the Committee on Labor and Public Welfare



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## APPENDIX

### COMPREHENSIVE HEW SIMPLIFICATION AND REFORM

#### "MEGA Proposal"

The materials in this book are all working drafts. Revisions to the papers are part of an on-going process.



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COMPREHENSIVE HEW SIMPLIFICATION AND REFORM:  
AN OVERVIEW

Every budget season brings us up against past decisions which have mortgaged the future. Potential for control "next year" always appear bleak due to financial and political constraints. In the past, the Department has evaded this dilemma with rhetorical initiatives for the upcoming year or by riding with the political forces, in the end making only minor changes at the margin.

The result is a Federal system out of control. Federal resources are over-committed, results are over-promised, and access to government services is unequal and fragmented. The Federal program structure has become so complex that it is unmanageable. Inter-dependencies among programs are ignored because they cannot be understood, leaving rational choice difficult, if not impossible.

We propose to tackle the crisis of the Federal system head-on. The Comprehensive HEW Simplification and Reform which we present here is a redesign of the entire Department of Health, Education, and Welfare. It is a return to first principles, the principles of New Federalism, which now lie largely unused. These are the tools, if used imaginatively and aggressively, that can provide the needed leverage to bring the Federal system under control.

The scope and depth with which those principles are applied makes this Reform wholly new. It touches every major area of HEW policy: it radically simplifies the Department's program structure; it narrows and focuses the Federal role; and it boldly decentralizes decision-making power to individuals, States, and local governments.

To comprehensively simplify and decentralize, we propose new initiatives in:

- o health insurance
- o student aid
- o welfare reform
- o special revenue sharing
- o consolidated programs of capacity-building to aid State, local and voluntary service suppliers.

These proposals will generate opposition, of course. No reform this bold and thorough could go unchallenged. But we welcome the coming debate. Whatever the questions of detail, we are confident that the concept is right for the times.

Just as important, Comprehensive HEW Simplification and Reform can generate consensus on needed retrenchment. Federal commitments threaten to exceed resources, both immediately and in the future. A strategy is needed to deal with over-commitment, and The New Federalism offers that strategy. This Reform meets over-commitment head-on, and helps us define a leaner, more focused Federal role cutting away the unsuccessful and unnecessary programs so that Federal promises can be kept and credibility gaps disappear. This does not mean we retreat to merely "less of the same." Through Reform we can live within our means while at the same time we improve the functioning of Federalism.

#### THE PROBLEMS WE FACE ....

The background of the crisis of control is a period of rapid change to which the Federal program structure has not yet successfully adjusted, and to which The New Federalism is the necessary response. Programs have proliferated, categories have hardened, and a sharp increase has occurred in the amount of Federal support of State and local activities.

These changes require Federal program adjustments which have not yet occurred. Dramatic adjustments must be made, because we are now in a crisis of complexity, fragmentation, and over-promise.

- o Complexity: Since 1961, the number of different HEW programs has tripled, and now exceeds 300; 54 of these programs overlap each other, 36 overlap programs of other Departments. The Federal government as a whole had no less than 530 categorical programs of aid to States in 1971.
- o Fragmentation: Federal rules and regulations for these myriad programs are narrow, restrictive, conflicting and overlapping; neither Federal nor State and local resources can be shifted from one narrow authority to another when the need arises. Prohibitions against joint funding, fund transfers, and commingling of funds make broad attacks on broad problems extremely difficult.

- o Over-Promising: We are progressively promising more and delivering less; in 1961, nearly all of HEW's authorizations (promises) were matched by appropriations (delivery), but in 1969 less than half were, and in 1971 only a third. We calculate that HEW's service delivery programs, which now cost \$9 billion, would cost \$250 billion if they were actually extended to all who need them. The inequities and the disappointments in this gigantic short-fall are fundamental to general unhappiness with government.

Complexity, fragmentation, and over-promise are all parts of the broader problem of non-manageability. Unless we simplify, consolidate, and promise only what we will deliver, we cannot control the Federal structure.

Events are thrusting on the Federal government a more important role in assistance to individuals and to lower-level governments, and a lesser role in direct service delivery. We have lagged in developing new program structures to reflect these roles. It is time for comprehensive Reform.

#### THE SHAPE OF REFORM ....

In light of the principles of The New Federalism we have examined literally every HEW program for possibilities of simplification and decentralization. We now find that we can plan in terms of just three broad program categories:

- o Assistance to families and individuals -- including social security, public assistance, health insurance, and student aid;
- o Assistance to States and localities -- including all grant programs to lower-level governments;
- o Capacity building -- including research and development, market and services development, and special manpower development.

In each of these broad categories, we have developed proposals for major simplification and decentralization. The proposals are spelled out in detail in the accompanying papers, but here we can highlight their major features.

#### Assistance to families and individuals

The Federal role in assistance to families and individuals is crucial, and it is growing. At the heart of The New Federalism is the strategy

of maximum responsibility and decision-making for individuals, using market incentives and the capacities of the private sector. By placing decisions in individual hands, we decentralize and simplify the tasks of government; the essential problem is to design necessary health, education, and income assistance so that it is at once simple, comprehensible, adequate and reliant upon normal incentives for private action in the public interest. We have developed three major new proposals which we believe meet this need.

Maximum Liability Health Insurance (MLHI) would replace Medicare and Medicaid, and would supplant FHIP and NHISA as the new Administration health insurance initiative. MLHI is designed to avoid the complexity and fragmentation of both Medicare and Medicaid and the proposed FHIP and NHISA. Many persons in need of health insurance are not and would not be covered under those programs, which are complex, hard to understand, and difficult to administer. The main features of MLHI are these:

- o It reverses the present "upside-down" character of health insurance. Currently, the easily-foreseen, routine, small expenses are covered, but major risks are not; under MLHI, the insurance would be placed where it is needed.
- o It will provide coverage for all Americans.
- o It will cover most medical expenses, including mental health treatment.
- o It will ensure that personal health expense liabilities do not exceed a maximum level, which is based on ability to pay.
- o There will be some cost-sharing for everyone, in order to discourage waste, but costs for the poor would be low.
- o It preserves a major role for private insurers in selling supplementary coverage and in acting as underwriters or fiscal agents.
- o It reduces payroll taxes, permits general revenue finance, and eliminates the need for income tax deductions for health expenses.
- o It will cost no more than NHIPA, and little more than present law; for States, it will save money.

- c Because of its extreme simplicity, it will clarify health options for the individual, and enable him to make his own decisions better.

Comparable simplicity is provided by a new Student Assistance Program in higher education. The general strategy underlying student assistance, in line with the principles of The New Federalism, is to increase the effectiveness of individual student decisions, by emphasizing student aid rather than institutional aid. Three tools would be used: grants for low-income students, guaranteed unsubsidized student loans, and State scholarship incentive grants. The new system would work like this:

- o Grants would be targeted on low-income students early in their college years; the poor, the isolated, and the deprived might otherwise under-invest in education.
- o Unsubsidized private loans to other students would carry premium-financed insurance against inability to repay.
- o States would receive grants if they emphasized student aid rather than institutional support, and if they allowed aided students to study outside the State.
- o Thus the system would assure access to education by low-income students, create an equitable student loan market, reduce discrimination against private institutions, and permit elimination of most higher education institutional aid programs.

Among all Federal programs of aid to individuals, social security is among the best, most adequate, and most popular, and we propose no major changes in it. But Family Welfare Reform (FWR) is still essential. Our plan for FWR avoids three weaknesses of H.R. 1: insufficient penalties for failure to work, wasteful and costly requirements for Federal day care and other services, and weak job and training provisions. FWR is a truly work-based welfare reform, but it avoids many of the problems of either the present program or the one proposed by the Senate Finance Committee. It would have these features:

- o Basic Federal benefit levels nationwide, with an option for reduced levels in low-wage States, and State supplements where desired.
- o Family benefits which reflect the presence only of persons classified as not available for work.

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- o Adults classified as available only if child care responsibilities permit, avoiding costly Federal day care programs.
- o All available persons assured training, a regular job, or if necessary a public service job, with strong incentives to work in a regular job.
- o Employer tax credits for hiring and successful training.
- o Stringent fraud-combatting provisions.
- o Total cost less than that of H.R. 1.

In combination, these three plans for health, education, and welfare assistance to individuals form the basis for effectively, simply and noncategorically assuring basic nationwide minimums of health, income and educational opportunity. They accomplish this at little or no increase in cost, and yet taken together they form a program structure far superior to the present one.

Only within the framework of a sound set of assistance-to-individuals programs can assistance to State and local governments be well designed. This is true because if basic individual needs are not met, the demand for proliferating categorical programs will rise. Uncontrolled, the demand will prevent the concentration on General Revenue Sharing and Special Revenue Sharing, which are essential for simplicity and decentralization under The New Federalism.

#### Assistance to State and local governments

We have created three broad sets of special revenue sharing programs — one each for health, education, and social services — which we believe take full advantage of the foundation of assistance to individuals. Many categorical programs can be reduced or eliminated, because MHI, Student Assistance, or FWR will now cover the need. Others can be consolidated, and the allocation of funds within broader limits can be left to States and localities. In total, these three revenue sharing packages consolidate 50 programs now funded at \$7.7 billion — one-fourth of all Federal grants to State and local governments.

This is a sweeping simplification and decentralization, but it is also a responsible one. Special revenue sharing is not a cover for an escape from proper Federal responsibility. Rather, it cuts through the existing tangle of categories, administrative structures, and regulations, and gives States and localities much greater decision-making freedom, but at the same time maintains the Federal requirements which are truly essential.



Health Special Revenue Sharing will look like this:

- o Nine programs are consolidated into one block grant of \$500 million.
- o Covered activities center on public health, including VD control, drug abuse, and alcoholism.
- o No special earmarks or pass-through requirements are imposed; States can allocate resources to fit their individual needs.

Education Special Revenue Sharing modifies and extends the 1971 HEW proposal, and has these features:

- o 35 programs are consolidated in elementary and secondary education.
- o Five special earmarks are imposed: for handicapped, disadvantaged, vocational education, impact aid, and support services.
- o The programs are funded at approximately \$4 billion.

Social Services Special Revenue Sharing will look like this:

- o Six major formula grant programs are combined in social services, child welfare, vocational rehabilitation, developmental disabilities, services to families, aging, and the non-experimental parts of Head Start.
- o 90 percent of the funds are earmarked for the poor.
- o Fee schedules are mandated for the non-poor and mandatory joint local-State planning processes are required.
- o The programs are funded at \$3.2 billion.

The three revenue sharing packages are detailed in the accompanying paper. Here, however, we emphasize three things:

- o These consolidations represent a quantum increase in decentralization and simplification, but at the same time they are responsible. Essential Federal priorities are protected.



- o They put us on the road to matching our performance to our promises: funds can be shifted to deal more fully with each State's greatest needs. We will stop fooling ourselves by promising to do all of everything for everyone.
- o The Federal establishment will stop exercising control over State programs in a degree of detail which is neither workable nor justified. Federal choice will center on the question of the level at which it wishes to support general ranges of State service provision.

We are now convinced that these three effects are desirable, and in fact essential if The New Federalism is actually to succeed.

#### Capacity Building

We have outlined plans for simplification and decentralization through comprehensive reform of assistance to families and individuals, and assistance to State and local governments. But assuring that persons and governments have funds at their command does not assure the capacity to supply their needs. A Federal role in capacity building is a necessary complement.

Many HEW programs already are designed to help both public and private organizations innovate, initiate, and train for service provision. We believe this help must be at the center of the Federal role. As in revenue sharing, however, much is to be gained by better targeting and by de-categorization.

- o We propose that 22 research and development authorities be consolidated into 6 broader ones, for better focus, coordination and planning, and for better use of very scarce R & D management resources.
- o We propose that 47 market and services development authorities be consolidated into 5, and that the focus be strictly time-limited aid for innovation and start-up, with loan guarantees for public construction.
- o We propose three consolidated manpower development authorities for the health, education, and welfare fields. Their budget should be reduced from the present \$1 billion to less than half that amount, since much of what they now do is badly targeted or unnecessary, and since the Student Assistance program for higher education will service many of these needs, and do it better.

#### THE WAY REFORM WORKS.....

Reform consists, then, of simplifying and decentralizing to improve assistance to individuals and to governments, and to improve capacity building. These elements of Reform are not independent -- they work together.

#### The cornerstone of the structure is Assistance to Families and Individuals.

- o Basic family needs are assured for health, for education, and for income.
- o The programs are designed for maximum individual choice, expressed through the private sector market place.
- o Taken together, the programs are comprehensive in coverage, adequate in their assistance levels, simple and understandable in operation, and sound in the incentives they create.

Building on effective Assistance to Individuals, many narrow programs can be eliminated or decategorized, and the demand for new ones will be dampened.

- o Enacting Maximum Liability Health Insurance allows us to eliminate separate programs of medical services for vocational rehabilitation, mental health treatment, and tax preferences for health services.
- o Enacting Student Assistance allows us to eliminate separate programs of higher education institutional aid and special manpower training subsidies.
- o Enacting Family Welfare Reform enables us to eliminate food stamps, cut through the tangled mess of AFDC, limit levels of social services spending, and hold down myriad categorical programs for the poor.

#### Assistance to Governments gives broad discretion to attack broad problems.

- o Fifty narrow programs become three broad ones.
- o Attention is focused on Federal priorities through earmarks, mandates, and incentives.
- o Decentralized decisions at the State and local level are relied on.

Capacity Building assures resources for innovation, testing, start-up and growth.

- o Scarce R & D management resources are freed from narrow categorization.
- o Market and services development is targeted on time-limited aid.
- o Manpower development is more carefully focused on real problems, real under-supply.

BUT WHO WOULD BE FOR IT?

We have now traced the broad outlines of Comprehensive HEW Simplification and Reform. We believe it is conceptually powerful and appealing. Yet the question remains, who would be for it?

The problems of gaining acceptance are clear:

- o The constituencies that have formed behind each narrow categorical program will be wary or hostile.
- o The minorities and the disadvantaged may fear that their interests are being abandoned by the Federal government.
- o States may be cool because the revenue sharing contains no new funds.

But we believe that with Presidential enthusiasm and leadership the Reform can succeed. We base our view on two factors:

- o Complexity, fragmentation, and over-promise are everyone's problem, and everyone knows it. With sustained educational effort we can gain support for changes.
- o Hence, the strength of this Reform lies in its comprehensiveness. Taken bit by bit, the fight against complexity, fragmentation and over-promise seems hopeless; but with a group of proposals which is sufficiently audacious and thorough-going, support for the general principles can overcome particular objections.

We therefore are enthusiastic about the chances of success. Our proposals effectively, comprehensively, and imaginatively address the need for simplification and decentralization, and we believe the American people will welcome them.

#### ASSISTANCE TO FAMILIES AND INDIVIDUALS

At the heart of activity in the Department of Health, Education and Welfare are programs which provide cash or near-cash benefits to families and individuals. Such programs have long been accepted as a legitimate public function, because they directly meet obvious needs to place a floor under the minimum command over goods and services which Americans will have. These programs are becoming increasingly a Federal responsibility, rather than a State and local one, for three reasons:

- Such benefits can often be distributed on the basis of objectively determined personal characteristics, such as age, family size, and income, so that local personalized administration is unnecessary.
- There are often large economies to be gained by centralizing the eligibility and benefit determination functions.
- If large State-to-State differences in eligibility and benefit levels are permitted, uneconomic migration could result, and difficulties of administration appear.

The process of Federalizing these functions is not, of course, complete, but the pressures in that direction are clear from the recent history of Welfare Reform.

Programs of this type appear in each major area of the Department:

- Health: Medicaid and Medicare, and the proposed FHIP and NHISA.
- Education: Higher education aid to students.
- Welfare: Social Security, Supplemental Security Income for the Aged, and Aid to Families with Dependent Children.

In the context of the principles of The New Federalism, programs of assistance to families and individuals occupy a key role.

- When problems of need arise, it is important to meet them in a way which permits decentralization of choice, maximum use of private sector markets and suppliers, and simplicity at the Federal program level.
- Programs of general benefit which provide cash or near-cash generally fit these characteristics. This is obvious

in the case of social security or welfare; but even in Medicare or student aid, the recipient retains a wide range of choice of private suppliers of services, and the criteria for granting benefits can remain relatively simple.

- The Federal program decision thus is limited to the size of the benefit to be given each person; no decision on specific suppliers or (in the case of cash) specific goods and services need be made.

If these assistance programs are to perform adequately their key simplifying and decentralizing role, however, it is essential that they be comprehensive in their coverage, adequate in their benefit levels, simple and understandable in operation, and sound in the incentives they establish for recipients.

- If they are not broad in coverage and sufficiently generous, pressure will be felt to add new programs. Very often, specific non-covered groups will press for narrow categorical assistance of a direct-service nature. When this occurs, the possible advantages of The New Federalism are lost.
- When the programs are not understandable, or they offer perverse incentives, public support for them is unlikely to be maintained, and their effects may be harmful in unforeseen ways.

Our examination of the programs of assistance to families and individuals in HEW has convinced us that improvements are both possible and needed. In the three sections that follow we outline, in turn, our proposals for a new form of health insurance, a new program of assistance to students in higher education, and improvements in social security and welfare.

AN ALTERNATIVE NATIONAL HEALTH INSURANCE PROPOSAL: A MAXIMUM  
LIABILITY HEALTH INSURANCE PLAN

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The Maximum Liability Health Insurance proposal presented in this paper arises from the recognition that the public's health concerns are dominated by the fear that they will be overwhelmed by costs catastrophic relative to their income, and that segments of the population are not receiving the care they should solely because of costs. Through a Maximum Liability Health Insurance program, one can devise a national insurance strategy which addresses these problems, is relatively simple and identifies a legitimate but not an overwhelming Federal role. Under the MLHI approach, all families would be treated equally with respect to their health insurance protection except to the extent that their health expenses and their ability to meet such expenses vary.

The net add-on to Federal spending of MLHI depends critically on the structure of the plan selected. In the example provided in this paper, net Federal outlays for MLHI would be about \$4 billion. But to accept a stand-pat position opens the very strong possibility that if Congress accepts the NHIPA approach, it will add the many billions of dollars needed to transform NHIPA into a true universal entitlement plan with a comprehensive benefit package. This could easily add \$5 billion of Federal revenues to the \$1 billion already allowed for under NHIPA. In addition, there would be several billion dollars added to the employer-employee contributory portion of mandated coverage. By switching to MLHI, therefore, we would not only introduce a more reasonable national health insurance proposal, but may in the process reduce the ultimate Federal price tag.

Major Problems with the Existing Health Insurance System

Lack of Adequate Financial Protection--Health insurance can be used to pay any type of medical expense, including services which are "routine" in the sense that they are nearly certain to be incurred over some period of time. The largest dollar volume of both private and government-provided health insurance is "first-dollar" coverage, providing benefits for the first days of hospital care and the initial bills of physicians and ancillary services. True, most health insurance plans require some minimum expenditure (\$50 or \$100) with cost-sharing of remaining expenses for physician and ancillary services in hospitals. With today's health care prices, most families easily exceed these limits for fairly routine items. The excess, when compared to a family's income

or what the family pays for automobile repairs or vacation is far from financially catastrophic. Therefore, most of today's health insurance can be labelled "first-dollar" coverage.

The largest financial health risk to a consumer results when he suffers a serious illness or accident, and the costs of treatment are disproportionate to his resources. The illness itself may severely impair his earning capacity, and it may be necessary for him to deplete his current and future earnings to finance the care. And if loss of employment results, insurance coverage may be lost entirely. Yet it is precisely the circumstances of major illness that are unprotected by much of the insurance available today. Essentially all private insurance policies have a maximum dollar limit on reimbursements, combined with interior limits on or exclusion of particular services, plus substantial cost-sharing provisions. Medicare, the biggest health insurance program, limits the maximum number of hospital days and increases cost-sharing requirements for the longest stays covered thus failing to cover those people most in need.

While there is a clear trend towards increasing the dollar limits or days covered under existing plans, it is an incremental approach to a much more pervasive problem. Medical technology will continue to add increasing numbers of high cost procedures, which will leave most health insurance plans with financial limits at least one step behind.

In many instances, therefore, present day health insurance coverage is upside-down in terms of providing protection against risk. Not surprisingly, the state of affairs creates some strange behavior. Consumers worried about the financial devastation of a major illness, and are unable to protect themselves adequately against such a risk. Concurrently, they pay large premiums to health insurers for first-dollar coverage and feel they have not "got their money's worth" over a year if they fail to receive large reimbursement checks. The contrast with other types of insurance could not be more extreme--it is considered peculiar to find the homeowner annoyed about not collecting on his fire insurance policy last year, or a family lamenting its lack of return on the husband's life insurance.

Lack of Universal Protection--Health insurance stands out as the major type of insurance protection which is critically tied to an individual's job. There are many reasons for this, economies of group purchase, relative ease of purchase and substantial tax savings both to the individual and to his employer. While these advantages are indeed real, the tying of health protection to employment has



created some of the most serious problems which the national health insurance debate is seeking to resolve. In particular, our current health insurance system leaves many millions of Americans with little or no financial protection against the high cost of receiving medical services.

About four-fifths of the population under age 65 have some form of private health insurance much of which is included as part of the "fringe benefits" package offered to workers. But among those covered by private health insurance coverage varies widely. Whereas over 90 percent of those earning in excess of \$10,000 have hospital and surgical coverage, for those earning less than \$5,000 the proportion with such coverage is less than 50 percent. Protection against medical cost arising outside a hospital is considerably poorer for all income groups. Problems of little or no in-depth coverage are most serious for five major groups: (1) those employed in less prosperous industries or firms, (2) those with low average levels of wages and salaries, (3) small firms which cannot avail themselves of lower cost group insurance, (4) the self-employed, and (5) the unemployed who are not on welfare.

The problems of lack of protection are compounded for those who have no fixed employer or who change jobs from time to time. Almost 75% of today's health insurance policies do not begin coverage until after 30 days of employment, with many withholding protection until after 90 days of employment. Many such plans also terminate coverage simultaneously with employment, although provisions are usually made for benefits to be paid if the beneficiary is hospitalized at the time of termination. Limited coverage is usually provided for some additional period, if at time of termination the enrollee is sufficiently disabled that he cannot work. In addition, almost all group policies allow the enrollee to convert to an individual policy when he leaves the group (employment). In most instances, however, the premiums associated with these individual policies are far in excess of those charged while the individual was a member of the group.

Therefore, the current health insurance system provides the poorest financial protection against health expenses for those least able to afford them. It is extremely difficult, even for the average worker to insure himself when he is healthy and earning a decent income against the possibility that in the future he could face the loss of his job and with it his insurance just at the time he most needs protection against very high cost medical bills. Failure to be able to transport his health insurance protection from job-to-job also acts to restrain job mobility which may be beneficial both to the worker and to his employer.

Alongside these formal employment-related insurance mechanisms, a rough-and-ready sort of "catastrophic" social insurance system does operate. Many destitute Americans have been able to obtain some medical treatment, largely financed in past years by unpaid bills of patients and today primarily by State-run Medicaid programs. But many others, equally impoverished by large medical bills, do not qualify for Medicaid assistance. Society has long attempted to be the insurer of last resort, but the present institutions are only effective when the individual's family has been reduced to indigency.

Problems with the National Health Insurance Partnership Act

The Administration in drafting its National Health Insurance Partnership Act (NHIPA) attempted to design a compromise plan which maintained most of the features of the existing health insurance system and extended basic coverage to many segments of the population not now protected. As part of ongoing HEW staff work, the external criticisms of NHIPA have been analyzed. They indicate certain deficiencies that we or the Congress will have to address if a true system of universal entitlement is to be constructed. Briefly, these concerns fall in the following categories.

- o The basic FHIP and NHISA programs will not cover over 11 million families and 4 million other individuals who either work for small employers, are self-employed or unemployed.
- o To provide universal protection will require the establishment of a complex and inherently difficult-to-administer system of "pool" coverage.
- o The total cost of providing pool coverage will approximate 10 billion dollars. How the burden of these costs will be shared between premium payments, subsidies by other insurers or a Federal payment has not been resolved.
- o FHIP and NHISA, in combination with Medicare, a residual Medicaid program, private health insurance and special pool coverage creates the general impression of an incomprehensive and non-equitable system of national health insurance.
- o The benefits under FHIP (limited as they are to 30 in-patient days of hospitalization and 8 outpatient physician visits) would leave many low-income families unprotected.

financially. NHISA provides better catastrophic coverage but is nonetheless limited to benefit payments of \$50,000 per individual with a \$2,000 per year replenishment.

- o Too much emphasis continues to be placed on paying for health bills which families can realistically budget.

In addition, by mandating health insurance coverage through the employer, the following additional problems are created:

- o The proposed system of financing would be regressive in its income distribution effects. NHISA would be financed by a fixed tax per employee without regard to his earnings. The benefits, too, are regressive, since the deductible and coinsurance structure is not related to income. Thus, the cost-sharing provisions would cause the low-income population to reduce their utilization more than it would the high-income population. (A deductible of \$100 on physician visits will have a greater effect on the consumption pattern of someone who earns \$5,000 annually than it will on someone who earns \$50,000.)
- o The economic effect of mandated coverage on the labor market is identical to an increase in the minimum wage of an amount equivalent to the employer's share of premiums (estimated in 1974 to amount to 12c per hour). The dislocation is greatest on those marginal workers who are at the minimum wage. A strong equity argument can be made that, if the Federal government wishes to mandate coverage, it ought to help pay for it.
- o Under NHISA, the employee is faced with having a new insurance policy every time he switches jobs and with potential lapses in coverage between jobs. Each time he changes employer, he faces a duplicate set of deductibles and the exclusion anew for six months of pre-existing conditions.

THE ADMINISTRATION'S NATIONAL HEALTH INSURANCE PLAN:  
- - A REASSESSMENT

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Introduction

The Administration proposed the National Health Insurance Partnership Act (NHIPA) because substantial segments of the American population were without adequate health insurance protection. NHIPA has two parts, the Family Health Insurance Plan (FHIP), a Federally-financed program for low income families, and the National Health Insurance Standards Act (NHISA) for employed populations. The design of NHIPA incorporated two major objectives: (1) integrating FHIP with the Administration's welfare reform proposals, and (2) building upon the existing system of private health insurance.

NHIPA contains many desirable features that are absent in competing proposals:

- o It would build on and improve the existing and highly successful system of private group health insurance.
- o It would improve Medicaid by replacing the State program for the AFDC welfare population by a national program.
- o It would provide a favorable environment for evolutionary changes in the delivery system, particularly with regard to HMO growth.
- o It has a realistic coinsurance and deductible structure that would encourage consumer cost consciousness.
- o It would extend coverage to many millions of Americans.
- o It does not require major new Federal expenditures.

As part of ongoing HEW staff work, external criticisms of NHIPA have been analyzed. We believe it prudent that these criticisms be given thoughtful review within the Administration. Consequently, we have engaged in simultaneous efforts to seek remedies to any deficiencies in NHIPA and to develop a substantially different approach to national health insurance. The deficiencies are discussed below under four headings: (1) lack of universal entitlement, (2) noncomprehensiveness of the benefit package, (3) the perpetuation of a patchwork system, and (4) adverse economic consequences.

### Lack of Universal Entitlement

NHISA combined with Medicare and the residual Medicaid program would fail to cover over 40 million people, although some of these would purchase insurance privately. To achieve universal entitlement, the following measures would have to be taken:

1. FHIP would have to be extended to low income singles and couples rather than being restricted to families with children. The estimated 1974 cost of so doing would be \$1 billion.
2. The problems of continuity of coverage for employees between jobs would have to be addressed. Under NHISA, as drafted, an individual who becomes temporarily unemployed between jobs is either uncovered or must purchase a policy from the pool (assuming the NHISA pool proposal is made workable). If he does take out pool coverage, in order to be insured during a short vacation or period of frictional unemployment, he has three policies--from the old employer, the pool, and the new employer--in rapid sequence, with all of the attendant paperwork and inconvenience. Furthermore, with each new policy, he faces a new set of deductibles and the six month exclusion of coverage for pre-existing conditions.
3. Provisions would be required to protect the enrollee against HMO insolvency, insolvency on the part of a self-insuring employer, and the failure of an employer to pay premiums. NHISA as drafted adequately handles carrier insolvency but not the other three situations.
4. The pools provided for in NHISA would have to be subsidized to make them workable. These pools would offer the basic NHISA plan to small employers, the self-employed, and the unemployed who would not be covered by governmental programs. It is generally recognized that, in the absence of a subsidy which would permit pool rates to be reasonable, all but a handful of individuals with the worst medical risks would opt out of pool coverage, and the prices that the pools would have to charge would be prohibitive. If the pool premiums were set at 25 percent over the rates that private insurers charged large employer groups, the resulting subsidy from outside the pools would be around \$2 billion annually, and an enrolled family would still have to pay \$500 annually for coverage. If the pool rate was 10 percent above the large group rate, the resulting subsidy would be \$2.6 billion.
5. Mechanisms would be needed to cover short-term employees through a plan having an employer contribution. The short-term employee--one who has not worked the prerequisite 350 hours for a single employer -- would not be covered by NHISA, and short-term employees are far less likely to have health insurance than long-term employees.

In summary, NHIWA would leave uncovered some of those in greatest need: low-income singles and couples, the person between jobs, the self-employed, and the marginal employee who is not a member of a strong union and who does not hold a steady job. Many of these persons will not buy insurance from the pools because of its high premiums, coinsurance, and deductibles.

#### Noncomprehensiveness of the Benefit Package

1. NHIWA and FHIP currently exclude outpatient drugs, mental illness benefits, and dental care. Furthermore, home health care and active treatment in extended care facilities are excluded from NHIWA.
2. FHIP coverage is limited to 8 outpatient physician visits and 30 inpatient hospital days annually, which creates a two-tiered insurance system--a restrictive one for the poor and another, more generous, one for the nonpoor. Providing the current NHIWA benefit package to the FHIP population would increase Federal outlays by \$165 million.
3. NHIWA has an upper limit in lifetime benefits of \$50,000. At the first-dollar end of the scale, while the cost-sharing is high for low-income families, it provides coverage for other families who could realistically budget for routine expenses.

#### The Perpetuation of a Patchwork System

1. NHIWA is difficult to understand, particularly for the general public.
2. Because it does not achieve universal entitlement to a comprehensive benefit package, a patchwork system of benefits would be generated, and Congress would find it tempting to enact further piecemeal remedies. The 1972 Social Security Amendments offer two excellent illustrations of the process. Medicare was extended to cover individuals receiving renal dialysis but not other catastrophic diseases. It was also extended to cover persons who collect disability insurance from Social Security, but with a 24-month waiting period. The rationale for the waiting period was purely budgetary, and over the next few years the waiting period will likely be reduced or eliminated, since the time of greatest medical and financial need is shortly after the onset of disability. These attempts to fill the most visible gaps are inevitably expensive. (Eliminating the 24-month waiting period would cost over \$1 billion annually.)
3. NHIWA has forced HEW to confront the whole issue of voluntarism--i.e., whether individuals should be required to obtain coverage--which would be moot under a Federal-financed system. Many individuals who do not receive the employer contribution will determine that they cannot afford NHIWA coverage privately or from the pools. This leaves



society with the dilemma of whether to help someone who, after failing to obtain coverage, suffers a financially catastrophic illness, a burden society has traditionally assumed.

#### Adverse Economic Consequences

Employer mandated health insurance coverage would have the following economic effects:

1. The income distribution consequences would be regressive with regard to both the financing and to a lesser extent, the benefit structure. NHISA would be financed by a fixed tax per employee that is unrelated to earnings. Thus, the proportion of earnings that would be devoted to NHISA premiums would be greatest among low income workers. The burden of cost-sharing would be regressive, since the deductible and coinsurance structure is not related to income. The cost-sharing provisions would cause the low-income population to reduce their utilization more than it would the high-income population. (A deductible of \$100 on physician visits will have a greater effect on the consumption pattern of someone who earns \$5,000 annually than it will on someone who earns \$50,000.)
2. The economic effect on the labor market of mandated coverage is identical to that of an increase in the minimum wage of an amount equivalent to the employer's share of premiums (estimated in 1974 to amount to 12¢ per hour). The dislocation occurs for those marginal workers who are at the minimum wage. A strong equity argument can be made that, if the Federal government wishes to mandate coverage, it ought to help pay for it.
3. Since small employers as a group offer their employees less generous health insurance benefits than large employers, they would be most affected by the requirement to offer a minimum benefit package.

#### Conclusion

NHIPA was intended to have a low impact on Federal outlays. As structured, the additional Federal outlays would only be around \$1 billion in 1974, including the offset that results from terminating the Medicaid program for the AFDC welfare population. In actuality, NHIPA could prove to be a good deal more expensive. It is unlikely that Congress would enact a program that does not come considerably closer than NHISA to achieving universal entitlement including covering low-income singles and couples, providing for the subsidy to the pools necessary to make them operational, and liberalizing the benefit package, particularly for FHIP. These three extensions would add \$4-5 billion annually in Federal outlays.



In view of some of the problems with NHIPA, a new approach warrants consideration that would:

- o Provide universal and continuous coverage for a broad range of medical services.
- o Cover only expenses for which the family cannot realistically budget.
- o Have budget effects that are consistent with the fiscal pressures of the 1970s.
- o Avoid adverse economic consequences, including reliance on employer mandated coverage.
- o Institute cost consciousness in a realistic manner.
- o Provide opportunity for both consumer choice and for a strong insurance market.
- o Avoid the administrative complexities of NHIPA.

As an alternative to NHIPA, a sample plan has been developed, called Maximum Liability Health Insurance (MLHI), which would replace the current Medicaid, and potentially the Medicare, programs. MLHI would provide catastrophic coverage to all Americans and would be financed by a progressively scaled surcharge on the personal income tax. Thus, low income families might pay \$5 annually for coverage, and rich families \$1200.

Under MLHI, the amount of the cost sharing would be related to income. A family of four with an income of \$5,400 would have a maximum liability of \$540 or 10% of its income, while a family earning \$50,000 would be liable for \$7,500 in expenses or 15% of its income. Since the average annual medical expense for a family of four is around \$1,000, fewer than 20% of American families will have claims paid under MLHI. The sale of private supplementary insurance to pay part or all of the MLHI cost sharing would be encouraged, thus, preserving most of the functions of private health insurance.

- o NHISA would fail to cover short-term workers, who, among employed populations, are perhaps the most in need of insurance. Although a system could be devised to cover short-term workers, it would necessarily be administratively very complex.
- o Because NHISA coverage is not mandatory, individuals may voluntarily not select such coverage or pressure might be brought by the employer not to select coverage, leaving the problem of caring for the individual who later does face high or catastrophic expenses.

Both the nation's long-expressed concern to make health care available when individual resources have been exhausted and the failure of private markets (and government Medicare policy) to provide complete major risk protection make a compelling case for national insurance to cover financially catastrophic health risks. Since some degree of last resort protection would otherwise be provided by government, it is important to make catastrophic health insurance compulsory to avoid having some persons decline premium payments but later become medically indigent cases for government support. This concept is at the heart of the Maximum Liability Health Insurance plan which is discussed in the next section.

#### An Alternative Proposal--Maximum Liability Health Insurance

As an alternative approach, this paper suggests a Maximum Liability Health Insurance (MLHI) plan which has the following attributes:

- o provides all Americans with financial protection against those, but only those, health risks which exceed their ability to pay
- o simplifies national health insurance systems
- o separates major health insurance coverage and its financing from employment considerations
- o removes all personal and corporate income tax subsidies for health insurance purchases and normal health care expenditures
- o eliminates the Medicare payroll tax

- o finances the program through Federal general revenues
- o reforms the existing Medicare system
- o eliminates the current Medicaid program
- o relies on private health insurance companies acting as either financial agents or underwriters.

The Basic Design -- The Maximum Liability Health Insurance plan has two basic properties: (1) its coverage is universal and therefore not directly connected with the labor market; and (2) it protects a family or an individual only against those financial risks which would substantially alter their lifestyle.

As envisaged here, MLHI would cover all U.S. citizens and would be financed from general revenues. Its universal coverage and compulsory financing features stem from the fact that:

- o society has decided to provide some type of last resort protection to all, when they have become sufficiently destitute;
- o most persons would voluntarily purchase such coverage if available at reasonable rates so that required financial participation is generally acceptable;
- o significant economies are realized by universal enrollment. The expense of collection "premiums" via taxes is insignificant, and statistical pooling of risk is achieved by enrolling everyone.
- o serious discontinuities in coverage arise when such health insurance is voluntary and tied to the job market. The people in greatest need of health care and with the fewest resources to pay for it are not covered via regular employment.

Compulsory Federal insurance has precedence in situations in which rare but financially ruinous risks can occur and lead to subsequent government assistance. The most recent example is the requirement that all FHA home loans carry flood insurance in flood-basin areas

of the country. Adopted after the weaknesses of Federal relief to Pennsylvania victims of hurricane Agnes became apparent, this policy will in time effectively eliminate one type of categorical programs--flood disaster relief.

Most health insurance plans offered today, and even the Administration's National Health Insurance Partnership plan, implicitly determine a risk to be of catastrophic magnitude if it requires certain quantities of services (e.g., days of care or level of expense) independent of the patient's resources. In the Maximum Liability Health Insurance plan, financial risk is considered to be best measured in relation to the financial resources of the family. To a middle-income family, medical bills of \$1,000-\$1,500 are serious though manageable, particularly if credit arrangements are available. But to a family in poverty such bills are devastating. Therefore, in setting the maximum liability levels it is important to relate them to the family's ability to absorb them.

There are, however, several special problems relating to coverage of the poor and the aged. These are discussed in a later section of the paper. In the remaining portion of this section, the MLHI benefit package is discussed in some detail and possible administrative mechanisms are explored.

MLHI benefits--The benefits which would be included in MLHI are quite comprehensive. Above the income-related cost-sharing, MLHI would pay the full cost of hospital room and board, surgical and medical services, and ancillary services. This aspect of MLHI would be similar to the full payment feature of the high option Blue Cross/Blue Shield plan available to Federal employees. MLHI would also pay for home and office physician visits and ambulatory health services provided by recognized institutions or providers, including hospital outpatient departments.

The most comprehensive or conventional insurance today has a maximum lifetime benefit. In contrast, beyond its cost-sharing provisions, MLHI would pay the full cost (each year) of all covered services without limit. Services such as prescription drugs and dental care would be covered; dental care would be limited to non-routine services (e.g., oral surgery resulting from an accident). Family planning services and well child care also would be included.

Two areas stand out in any health insurance proposal because of the difficulties they present--mental illness and long-term care. Long term care is dealt with in detail below since its provisions involve other coverage under MLHI and cut across all diagnostic lines.

All active treatment of mental illness would be covered under MLHI. This includes both inpatient and outpatient care, and the services provided by physicians, psychologists and supervised paraprofessionals. Purely custodial care would continue to be the responsibility of individuals and of State and local governments. It should be noted, though, that most individuals suffering from mental illness do not require long-term custodial care. Trends in utilization of inpatient facilities have changed dramatically in recent years, largely because of the widespread development of community-based delivery systems for mental health services. While admissions to State and county mental hospitals have increased 9.2 percent between 1969 and 1971, the end of year resident population has actually decreased by 17 percent. We may, therefore, conclude that the bulk of all long-term care and mental health services would, by their present definitions be covered under MLHI.

The problem of including long-term care under MLHI is one largely concerned with providing long-term semi-skilled services with both medical and non-medical aspects. Many persons, particularly the aged, disabled, and mentally retarded are in need of care which is less comprehensive than that provided in a hospital. Yet they require institutional services. Because of the high cost of such care, the MLHI program would establish a long-term care benefit that would make certain that the health needs of such persons are met but without coverage of custodial care that is not a medical service. When the Medicare program was being established, it faced a similar problem. The availability of extended care services would often allow a patient to be shifted from more costly inpatient hospital care into less expensive extended care.

The long-term care package under MLHI would cover that care provided by a skilled nursing facility, i.e., services provided directly by or requiring the supervision of, skilled nursing personnel; or skilled rehabilitation services, which the patient needs on a daily basis, and which as a practical matter can only be provided in a skilled nursing facility. This plan would have the advantage of avoiding payment for custodial care, but would cover medically necessary long-term care. As under Medicare, a person would have to be an inpatient in a hospital for at least three days before he would be eligible for admission into a skilled nursing facility.

The major difference between the MLHI and Medicare benefits would be in the length of the benefit period. Medicare now provides for payment of up to 100 days per benefit period. MLHI would cover without limit, the number of authorized medically necessary days (including both hospital and nursing home stays). An MLHI utilization review committee, or the community's Professional Standards Review Organization (PSRO) would work with utilization review committees already existing for the hospital and skilled nursing

facility. Prior to admission and again at periodic intervals, this committee would review the patient's case and decide whether further treatment is necessary in the current setting. It may recommend discharge, care for a few more days, continued coverage, or transfer to a different level of care. If it suggests a continuation of benefits (and there is no objection from the institution's utilization review committee) the patient would continue to stay in the facility. Such a committee would help to limit unnecessary stays in the skilled nursing facility (or unnecessarily long stays in the hospital), as well as monitor the utilization of the health care purchased under MLHI, but would allow those patients who need extended care to continue receiving it in either a hospital or a nursing home. It is important to note that while each area or hospital and nursing home would have their own utilization review procedures, MLHI would establish an overall review committee to exercise overall coordination.

The MLHI program should also provide for home health services in a manner similar to Medicare. It would offer up to 200 home health visits per spell of illness.

Certain long-term care services, primarily custodial, such as those provided in an intermediate care facility are currently available to Medicaid beneficiaries but would not be covered by MLHI. Today roughly 30 percent of Medicaid expenditures are for long-term care of all types. Under MLHI, the abolition of Medicaid will in effect provide States with new revenues, allowing them to maintain and increase their current expenditures on long-term care not provided by MLHI.

Administration-- There are essentially four methods of administering an MLHI plan.

1. Completely Federally-run System -- Eligibility standards and claims processing done by Federal employees.
2. Intermediary Approach--A Federally-regulated and controlled system with private companies responsible for claims processing and most contact with providers (current Medicare approach).
3. Private Underwriting Approach--Eligibility standards established Federally with very limited Federal control on the day-to-day operation and underwriting activities of Federally-certified private carriers.
4. Mandated Coverage--All Americans required to purchase specified coverage from private carriers.

In the spirit of building on the capacity of the existing health insurance system and in order that the MLHI plan, paid for by Federal general revenues, will provide protection to all Americans, options 1 and 4 are ruled out.

Option 2 would be similar to the existing Medicare program and that proposed for FHIP. As fiscal agents of the Federal government, Medicare intermediaries are required to carry out rules and regulations established by the Federal government. This has had the advantage of putting the might of the Federal government behind certain desirable changes in the way providers operate. It has had the disadvantage of requiring the private carriers continuously to change their operation policies as new Federal directives are issued.

As an alternative to the private/intermediary approach, the following private underwriting system is suggested. The system outlined below is just one of several which could be devised to make maximum use of the private health insurance underwriting capacity, while still maintaining the basic outlines of the MLHI approach.

Outline of a private/underwriting MLHI system--

- o Federal government establishes eligibility of each family for MLHI coverage using previous year's income tax return and records on income assistance and other transfer payments
  - mechanism established for individuals to report a major change in income class (up or down after filing of income tax return)
- o MLHI voucher is sent to each family to be redeemed either through an employer or individually with a government-certified private health insurance carrier. This voucher designates the family as a member of a particular income class.
- o A limited number (perhaps three to ten) private insurance companies would be certified to sell MLHI coverage in each area. Certification would be based on financial solvency, past performance and quoted rates.
- o Private insurer informs Federal government of the number and types of individuals (size of deductible, ages, family size and region) to be covered under its program.
  - Individuals also inform government as to the company providing this coverage. This acts



both as a check on the accuracy of the insurer's statement as to the individual for whom he is providing coverage, and assures that all eligibles receive coverage.

- o Government negotiates a yearly premium rate with each insurer based on the group it covers.
- o All future contact is between individual (employers) and private insurance underwriters.
- o Individuals can petition government if private insurer fails to provide stated coverage.
- o Government establishes a permanent staff to concentrate on those aspects of health insurance which cannot be handled by each company alone, such as

--level of benefits

--procedures for effective utilization review

--mechanism for minimizing cost escalation

Before selecting the preferred administrative approach it is important to determine whether all families should be income-tested each year. The private/underwriting approach assumes that the Federal income tax reporting system, plus the system designed to determine eligibility for income assistance, could be modified relatively simply to provide MLHI vouchers. In essence under such an approach all Americans would be income-tested each year to determine their MLHI eligibility.

As an alternative, families could be given a form to be filled out and retained by them indicating their likely MLHI eligibility level. Only in cases where the family estimated that they had exceeded the deductible level, would they contact the government and request MLHI payments. This would substantially reduce the number of families reporting each year. This latter system would not require the use of private carriers underwriting the plan. Private insurers could still function, however, as fiscal intermediaries. Under both systems, many of the payments will be made after the fact and therefore directly to the individual.

The vouchers system depends critically on the ability to use the Federal income tax reporting system with few modifications. If this is not possible, and a new income reporting system is needed, there seems to be little justification in not using the intermediary approach with eligibility verified only for those asking for MLHI payments.

At the writing of this paper, we are withholding recommending a preferred approach pending an analysis of what modifications would be required of the existing Federal income tax reporting system.

#### Impact on the Consumer

A complete policy for national health insurance, while primarily an instrument for protecting the individual or family against the risk of unusually costly care and financing its purchase, should:

- o enable persons to budget their health expenses without major disruption to their living standard or restrict their use of needed medical care;
- o encourage both consumers and providers to achieve appropriate levels of health care utilization.

Large numbers of employees, directly or through bargaining agents, today elect "high option" health insurance policies when given the choice of more limited coverage. The high option plans typically include both greater protection against very large expenses and reimbursement of a greater proportion of first-dollar health expenses than is available through low option policies. This preference for more comprehensive coverage reflects at least four separate factors:

- o demand for catastrophic protection
- o the tax-free nature of the health insurance premiums
- o ignorance of the true risks and real costs of insurance
- o the convenience of having most health bills paid by another party.

Maximum Liability Health Insurance will satisfy the first need, while full taxation of premiums will allow consumers a neutral choice of additional insurance or other goods and services. Mechanisms to promote informed decisions about supplementary insurance and to provide alternative means of budgeting health expenses could be developed as part of a national health insurance strategy.

Budgeting Health Expenses -- A major advantage of the MLHI approach to national health insurance is the simplification of private supplemental insurance policies that would result. With an easily understood maximum expense guarantee from MLHI, consumers would be much better able to evaluate the benefits offered by private policies in terms of the family's potential liability for health care expenditures. Decisions about purchasing supplementary insurance would be reduced to a comparison of how much dollar coverage is provided, how much cost-sharing remains for family payment, and the premium expense. Policies of competing companies could be easily and directly compared. With a guaranteed maximum liability, consumers would be relieved of the continual urge to buy more coverage against potentially unlimited risk.

We expect a large continued demand for insurance that supplements MLHI. The economies of employer-related group insurance would continue to generate substantial business. Because of the inherent simplification of personal health expense risk resulting from the MLHI-type plan, detailed regulation of the terms of private insurance should be unnecessary. It would be highly desirable to pass a national Truth-in-Insurance Act, requiring standardized presentation of key cost and benefit data, such as total annual premium, average benefits paid, average cost-sharing payments, and maximum liability, as well as any limits on eligibility or specific services.

Because the MLHI plan has an income-related deductible, it will be necessary for those desiring supplemental health insurance protection to purchase such coverage in the form of specific increments of filling in the deductible amount. Insurance companies would probably have to sell such coverage in, say, increments of one or two hundred dollars, moving up to the maximum level of the deductible of the MLHI plan selected. Employees would be given a form which includes all the possible combinations that they could select and the prices of each segment. This approach would be similar, although more complicated, to that used to purchase term life insurance for employees based on their annual wage. A group policy is written, but the amount varies with each employee. The employer could subsidize such coverage by a fixed dollar amount or, if he wishes, have the amount increase with the earnings of the worker. Much of the administrative cost savings of group coverage still could be realized under such a plan. All premiums, whether paid by the individual or his employer, would be fully taxed.

Complete insurance is particularly costly because most of the time it is paying bills which occur almost routinely. On the average, a family will find its health costs lowest if it fully self-insures all health expenses not covered by the catastrophic plan. (Example I) In doing so, however, it exposes itself to some uncertainty about what those costs will be from one year to the next. Suppose that MLHI were to guarantee that its total health expenses could not exceed \$1000 in any year. Suppose further, that without any supplementary insurance the family's total health expenses would average about \$450. But that as the proportion of the family's bills paid by insurance increased, its

purchase of health care services also increased (due to the fact that most of the care was essentially free, at time of purchase.) If it budgets for average expenses of \$450, it would be exposed to possible further expenses of up to \$550.

EXAMPLE I  
No Supplemental Coverage

Self-insurance of all health expenses  
below the maximum liability level of  
\$1000

Total Health Expenses \$450

|                             |      |
|-----------------------------|------|
| Paid by Insurance . . .     | \$ 0 |
| Insurance Premium . . . . . | 0    |
| Out-of-Pocket . . . . .     | 450  |

This risk can be substantially reduced at relatively low cost if a supplementary policy with a significant deductible is purchased. By payment of about \$180 premium (Example II) the family would fully insure expenses between \$500 and \$1000. However, its average health expenses would increase to \$500 or \$50 more than if it carried no insurance as in Example I. Many families would find this increased protection worthwhile, budgeting about \$320 for out-of-pocket expenses and \$180 for premiums. The unbudgeted risk is then reduced to \$180.

EXAMPLE II  
Partial Supplementary Coverage

Partial supplementary insurance,  
covering all expenses from \$500  
to \$1000, with a \$500 deductible.

Total Health Expenses \$500

|                             |       |
|-----------------------------|-------|
| Paid by Insurance . .       | \$150 |
| Insurance Premium . . . . . | 180   |
| Out-of-Pocket . . . . .     | 320   |

Complete certainty about health costs with no out-of-pocket expenses, is displayed in Example III. By paying a \$650 premium, the family reduces the variation in health expenses to zero. Since such full protection increases the average health bill above the no insurance amount by \$200 per year, many informed consumers are likely to regard this amount as excessive, especially when compared with the partial insurance of Example II, in which total health expenditures increased by only \$50.

EXAMPLE III  
Complete First-Dollar Coverage

Complete supplementary insurance,  
covering all expenses from \$0  
with no cost-sharing

|                             |              |
|-----------------------------|--------------|
| Total Health Expenses       | <u>\$650</u> |
| Paid by Insurance . .       | \$540        |
| Insurance Premium . . . . . | 650          |
| Out-of-Pocket . . . . .     | 0            |

Because many small bills are paid under first-dollar coverage, administrative costs are high (In Example II and III, a 20 percent administrative cost factor is used to compute the insurance premium). In Example III, average spending for health care (aside from administrative costs of health insurance) is assumed to rise by \$90 above the no insurance rate of \$450. This increased spending is included to adjust for the likely possibility that when the cost of care is reduced to zero at time of purchase, families will use more care than they would if they paid the full cost.

In place of insurance to pay routine expenses, two types of budgeting may be considered. A health credit card approach with some degree of interest subsidy or default guarantee, would allow patients to spread expenses over a reasonable post-illness period when earning capacity has been restored. The credit card service could be privately provided, as a new line of business for present lenders and perhaps health insurers, with provision for FHA-type interest assistance and guarantee. A second mechanism, a health savings account, would encourage the consumer to make monthly payments into an account with balances held in escrow for health expenditures. Funds not spent at the end of a year could be withdrawn or left on deposit, at the consumer's choice.

For the population receiving income assistance, the provision of an escrow account is easily accommodated into the monthly check-writing process. For the employed population, such an account could be established through the employee's payroll office as an alternative, or supplement, to deductions for any supplementary insurance.

A policy which promotes development of budgeting mechanisms in conjunction with catastrophic insurance protection has important cost-reducing effects on total health expenditures. Consumers who save and, when necessary, borrow to meet smaller medical bills avoid the administrative costs of third-party reimbursements. These costs, for the relatively small expenditures covered by supplemental insurance, can be a large proportion of the total bill. In addition, since consumers will in most cases pay the full price of care for the routine services they use, the tendency to use unnecessary amounts of care is checked by the consumer's own pocket-book.

Utilization of Care -- There are two sides to the utilization coin. Underutilization of more or less routine health services occurs when a person's income is limited and other basic needs compete with medical expenses in his budget, or when he fails to obtain care which would prevent more serious or more costly illness at a later time. Low income and ignorance of the health system are presumptive indicators of possible underutilization.

Although equal amounts of care for persons at all income levels is a dubious goal, minimum levels of care is an appropriate objective, particularly where there is compelling evidence that timely care reduces the long-run cost of otherwise more serious illness. Prenatal and early child care are services of this type, as are perhaps the broader range of fertility-related services. By tailoring insurance benefit to income levels, financial incentives can be created so that the lowest income groups increase utilization. However, setting health insurance benefits, and thereby the net price of services to the patient, is but one means of affecting the level of utilization of services. Particularly in the case of preventive services, appropriate levels of use may be more effectively promoted by health education activities and direct requirements. Schools and employers, for example, could require that persons shall have received particular services as a condition of enrollment or employment, as is done today for a very limited number of tests for communicable diseases.

Special subsidies for specific services would greatly complicate the structure of MLHI. If extended to the non-assistance population, these subsidies would substantially increase claims processing requirements, defeating the attractiveness of a Federal program that would require payment of claims for only a small portion of the insured population in any one year.

If special subsidies are deemed desirable, a more attractive alternative would be to require inclusion of those benefits in private supplementary insurance policies. This approach would reach a large proportion of the employed families. A mixed strategy would be to include the special subsidies in MLHI only for assistance-level families (who face coinsurance but no deductibles).

The other side of the coin, overutilization, is often the result of the structure of insurance benefits. Distortions in the type of utilization are now well recognized as resulting from coverage of some services and not others (e.g., inpatient but not outpatient care). Quite simply, the prices as viewed by patients and their



physicians are badly out of proportion to the real costs of the services, thereby creating incentives to use the services for which the patient pays the lowest net price, as opposed to the lowest cost, service.

Similar distortions in the amount of total utilization occur among consumers at middle- and upper-income levels. When the major proportion of health expenses is reimbursed by insurance, patient/physician decisions about hospitalization, length of stay, frequency of visits, etc., are frequently determined more by factors of convenience than by the opportunity costs of the health resources being used up.

By providing appropriate financial incentives in insurance policies, the distortions of overutilization can be limited. Significant levels of cost-sharing, through deductibles and copayments, and similar benefits for equivalent but alternative modes of treatment should be central to the insurance structure.

#### A Possible MLHI Plan

In order to illustrate the functioning of MLHI, a specific example has been developed. While the general features of this plan have been designed to meet the objectives of universal coverage and income-related protection against financial catastrophe, it is important to emphasize that the MLHI approach does not depend on the specific values proposed in this plan. The design of a best set of MLHI parameters is an important, but basically technical problem. The overall cost of MLHI can be lowered, or raised, by changing the cost-sharing parameters. Modifications can be introduced to adjust benefits for variations in family size. A broader definition of income than that used for Federal tax collection will improve the equitable assessment of ability to pay.

The central MLHI feature is that a family's financial burden for health expenses cannot exceed a maximum amount related to its income. In the accompanying table the maximum health expenses paid by a family rise from \$36 below \$2,400 per year up to 15 percent of a year's income for families earning more than \$12,000. Over this income range, \$0 to \$12,000 covering half of the families in the country, the maximum burden is an increasing fraction of income, rising from three percent at \$1,000 to 15 percent at \$12,000, reflecting the very limited resources available for medical care in family budgets at the lowest levels. Above \$12,000 income per year, the plan limits maximum expenses to a constant 15 percent fraction of income.

Since a large proportion of families who face a maximum cost of only \$200 or \$300 would exceed this amount of health care in a year, it is desirable to extend the range of total health expenses over which such families pay some part of the cost. This can be most simply achieved without raising the maximum liability to the family, by requiring it to pay a fraction of the total health expenses up to some larger total amount, beyond which the insurance plan makes full reimbursement. That is, a coinsurance or percent of the bill is used rather than a flat amount where with the consumer it pays all (a deductible).

In the MLHI example plan in the \$3,600-\$4,800 income bracket, a family is required to pay 50 cents of each dollar of medical care, until total expenses reach \$720. At that point, the family has paid \$360 directly, has incurred its maximum liability, and any further expenses are not subject to cost-sharing.

This use of coinsurance to extend the range of consumer sensitivity to health expenses has several advantages. For low-income consumers it provides a much-reduced price of care for the most frequent health bills. At the same time it limits "free" care to a considerably smaller number of instances. A possible disadvantage of a coinsurance rate on all bills is the potentially high administrative cost that this will entail. But since without such a coinsurance feature most low-income families would exceed their maximum liability and make claims, a large claims processing activity is necessary anyway. In addition, the claim handling activity can be directly linked to the monthly income reporting and check-writing process to be set up for families and adults receiving income assistance.

Beginning at \$6,000 of income, the family's liability is for the full cost of the initial health bills it incurs. As presented in the table, this "deductible" is set at 10 percent of income (\$650 at \$6,500 per year, \$2,450 at \$24,500 per year, etc.). The effect is that a significant proportion of families will not incur expenses in a single year large enough to collect reimbursement benefits from the MLHI plan.

If a family's financial liability ended when it had incurred expenses of 10 percent of income, for the remainder of the year it would have little incentive to limit further health expenses. By providing for a reduced rate of cost-sharing above the deductible, the range over which the family is sensitive to costs can be extended.

In the table we have doubled the cost-sharing range so that above \$7,200 of income consumers pay some part of medical bills until they total 20 percent of income. But, by providing for partial reimbursement in the 10 to 20 percent range, the overall family liability is limited to at most 15 percent of income. Thus, a family earning \$7,500 a year would be responsible for all of the first \$750 of medical bills. If it had higher expenses, it would pay for one-fourth of them until total family payments reached \$938. At that point, the liability limit for this income class has been reached, and any further bills would be reimbursed in full by MLHI. Above \$12,000 family income, the coinsurance rate is raised to 50 percent for a limited additional amount of expenses.

#### Cost Estimates

For FY 1973 the MLHI plan would require \$35.2 billion in Federal expenditures. To offset this, about \$31.3 billion of current Federal programs would be eliminated leaving a net add-on of \$3.9 billion.

In making these projections the variation of cost-sharing and liability limits with income levels has been adjusted to account for expected increases in money income throughout the population, i.e., the proportion of families at any given level of deductible/coinsurance. The maximum liability is assumed not to change. The

TABLE 1

## MAXIMUM LIABILITY HEALTH INSURANCE

| Family Income Level | Family Pays of | Bills Up To | Plus | of Add'l Bills Amounting to | Maximum Liability Amount | Percent of Income |
|---------------------|----------------|-------------|------|-----------------------------|--------------------------|-------------------|
| \$0-2,399           | 5%             | \$ 720      |      |                             | \$ 36                    | 3%                |
| 2,400-3,599         | 20%            | 720         |      |                             | 144                      | 4.8%              |
| 3,600-4,799         | 50%            | 720         |      |                             | 360                      | 8.5%              |
| 4,800-5,999         | 75%            | 720         |      |                             | 540                      | 10%               |
| 6,000-7,199         | 100%           | 720         |      |                             | 720                      | 10.9%             |
| 7,200-8,399         | 100%           | 780         | 25%  | \$ 780                      | 975                      | 12.5%             |
| 8,400-9,599         | 100%           | 900         | 25%  | 900                         | 1,125                    | 12.5%             |
| 9,600-10,799        | 100%           | 1,020       | 25%  | 1,020                       | 1,275                    | 12.5%             |
| 10,800-11,999       | 100%           | 1,140       | 25%  | 1,140                       | 1,425                    | 12.5%             |
| 12,000-13,199       | 100%           | 1,260       | 50%  | 1,260                       | 1,890                    | 15%               |
| -                   | -              | -           | -    | -                           | -                        | -                 |
| -                   | -              | -           | -    | -                           | -                        | -                 |
| -                   | -              | -           | -    | -                           | -                        | -                 |
| 28,800-29,999       | 100%           | 2,940       | 50%  | 2,940                       | 4,410                    | 15%               |
| etc.                | etc.           | etc.        | etc. | etc.                        | etc.                     | 15%               |

For purposes of calculation the middle of each income band beginning with \$7,200 was chosen.

estimates include rates of increase for medical prices and utilization similar to those projected for Medicare and Medicaid.

TABLE 2

Cost Estimates of MLHI  
(billions of dollars)  
1976

|                                                      |             |              |
|------------------------------------------------------|-------------|--------------|
| MLHI Federal Expenditures                            |             | \$35.2*      |
| Under age 65                                         | 19.5        |              |
| Age 65 and over                                      | <u>15.7</u> |              |
| Reduction in Federal Spending                        |             |              |
| Medicare                                             | 16.5        |              |
| Federal Medicaid                                     | 7.1         |              |
| Revenues from eliminating tax subsidies of insurance | 7.0         |              |
| Ending categorical health services                   | 0.7         | <u>31.3*</u> |
| Net Addition to Federal Expenditures                 |             | <u>3.9</u>   |

\*Including administrative costs.

The States would have a large portion of their Medicaid expenditures picked up by MLHI. We expect, however, that they will continue long-term custodial care services not now covered under Medicare and would assume that part of the long-term care currently paid by Federal Medicaid which will not be covered under MLHI. Under these assumptions, States would have a net reduction in Medicaid spending of about \$2 billion. There is also the unresolved problem of what would happen to the \$2.0 billion in VA appropriations.

We have included the personal and corporate income taxes foregone, \$7.0 billion in 1975, in the revenues available to finance MLHI. Under current law, premiums paid by employers escape taxation entirely, while personal premium payments are something akin to

long-term capital gains--they are taxed at (approximately) half of the otherwise applicable tax rate. With Maximum Liability Health Insurance universally available, any need to subsidize the purchase of insurance (or allow deductibility of large health bills, a much smaller subsidy) to mitigate financial catastrophe is removed.

The "loophole" nature of this form of employee fringe benefit has had the expected effect of rapidly expanding the amount of routine health care covered by insurance. Indeed, for middle- and upper-income taxpayers, who benefit most from this deduction, it is frequently the case that their total health costs are significantly reduced, on average, by arranging for employer-paid insurance, rather than direct personal payment of health bills; the administrative costs included in the premiums are more than made up by the lower tax liability to the employee.

With MLHI in effect, eliminating the tax subsidy of insurance premiums will establish a neutral environment for individuals to choose whether to purchase private supplemental insurance or to budget for most routine health bills by personal saving.

Two additional Federal offsets should be kept in mind. FHIP benefits, if unchanged in 1976, would cost \$1.0 billion more than the AFDC portion of Medicaid they would replace. Second, if as is likely a ceiling is placed on the premiums for the "pools" added Federal expenditures could rise by between \$1.2 billion and \$2.6 billion. These added costs could be added to the mandated group premium rates, but they are still cost increases.

If the original HEW proposal to set the pool premium at 110 percent of the average group rate was ultimately adopted, the net subsidy would be \$2.6 billion and if this subsidy was paid through Federal funds, the increase in expenditures under NHIPA, and MLHI would be about the same. In addition, if as is likely, there is both an expansion of FHIP to include singles and childless couples (\$1 billion add-on), plus an extension of the benefit package for both FHIP and NHISA (\$1 billion), the ultimate impact on Federal expenditures of adopting the MLHI approach could be to reduce Federal spending by \$2 billion a year.

#### Comparison of MLHI with the NHIPA/Medicare System

This section compares the benefits provided under the example of an MLHI plan with those provided under NHISA, FHIP and Medicare. The tables illustrate each plan as it affects families with a particular income level and stated amounts of covered medical expenses. Total cost of coverage includes both the premium and direct expense. An attempt is made also to allocate the tax burden of the MLHI plan, called the MLHI tax surcharge by income group. Family medical expenses of \$50, \$600, \$1,000, and \$15,000 illustrate respectively low, moderate, average, and catastrophic expenses for a family of four; or in the case of Medicare, for a couple. Comparisons between plans for the most part are based on total cost (direct expense plus premium/surtax) as a percent of income. It is important to bear in mind in these comparisons that they are only for individuals eligible under the plans and for covered expenses. Particularly under FHIP and NHISA both eligibility and coverage is rather restrictive.

Comparison of MLHI and NHISA--NHISA would provide comprehensive benefits (up to \$50,000 per person and a restoration of \$2,000 per year) to employees and their dependents subject to a two-day deductible on hospital room and board, and a \$100 deductible on most other services, with a 25 percent coinsurance on all further expenses. After a person has received \$5,000 in covered services, all further cost-sharing for that individual and his family is waived for that year and the next two years.

Table 3 compares the costs and benefits of NHISA and MLHI for families with incomes of \$6,001, \$10,001, \$20,001, and \$50,001. Neither system would permit reimbursement for services to families with very low expenses (\$50). When the NHISA premium (\$406) is added to the direct expense, the total cost of NHISA coverage becomes \$456. Under MLHI, the tax surcharge ranges from \$95 to \$1734. The total cost of MLHI coverage (surtax plus out-of-pocket) is lower than that of NHISA. For incomes up to \$10,000 under either plan, the total cost of coverage does not constitute a large percentage of family income, with the greatest burden under NHISA occurring at the lowest income, \$6 percent of income for the \$6,001 family, and under MLHI at 3.4 percent for incomes of \$50,001.

For expenses of \$600, the individual covered by NHISA must pay \$315 in direct expenses, plus the premium of \$406, totaling \$721. Under MLHI, the individual would not exceed the deductible, requiring direct



TABLE 3  
COMPARISON OF TOTAL COSTS AND BENEFITS OF NHISA AND MLHI  
Family of 2 Adults, 2 Children

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| FAMILY INCOME         | ANNUAL MEDICAL EXPENSES 4/ |  |       |  | \$500 |  |        |  | \$600  |  |        |  | \$1,000 |  |        |  | \$15,000 |  |        |  |
|-----------------------|----------------------------|--|-------|--|-------|--|--------|--|--------|--|--------|--|---------|--|--------|--|----------|--|--------|--|
|                       | NHISA                      |  | MLHI  |  | NHISA |  | MLHI   |  | NHISA  |  | MLHI   |  | NHISA   |  | MLHI   |  | NHISA    |  | MLHI   |  |
| \$6,001<br>(31.4%) 2/ | 50                         |  | 50    |  | 315   |  | 600    |  | 415    |  | 720    |  | 1,415   |  | 720    |  | 1,415    |  | 720    |  |
| Direct Expense        | 406                        |  | 95    |  | 406   |  | 95     |  | 406    |  | 95     |  | 406     |  | 95     |  | 406      |  | 95     |  |
| Premium/Tax 3/        | 456                        |  | 145   |  | 721   |  | 695    |  | 821    |  | 815    |  | 1,821   |  | 815    |  | 1,821    |  | 815    |  |
| TOTAL                 | (7.6)                      |  | (2.4) |  | (12)  |  | (11.5) |  | (13.6) |  | (13.5) |  | (30.3)  |  | (13.5) |  | (30.3)   |  | (13.5) |  |
| (% of Income)         |                            |  |       |  |       |  |        |  |        |  |        |  |         |  |        |  |          |  |        |  |
| \$10,001<br>(55.1%)   | 50                         |  | 50    |  | 315   |  | 600    |  | 415    |  | 1,000  |  | 1,415   |  | 1,250  |  | 1,415    |  | 1,250  |  |
| Direct Expense        | 406                        |  | 207   |  | 406   |  | 207    |  | 406    |  | 207    |  | 406     |  | 207    |  | 406      |  | 207    |  |
| Premium/Tax           | 456                        |  | 257   |  | 721   |  | 807    |  | 821    |  | 1,207  |  | 1,821   |  | 1,457  |  | 1,821    |  | 1,457  |  |
| TOTAL                 | (4.6)                      |  | (2.5) |  | (7.2) |  | (8.1)  |  | (8.2)  |  | (12.1) |  | (18.2)  |  | (14.5) |  | (18.2)   |  | (14.5) |  |
| (% of Income)         |                            |  |       |  |       |  |        |  |        |  |        |  |         |  |        |  |          |  |        |  |
| \$20,001<br>(86.4%)   | 50                         |  | 50    |  | 315   |  | 600    |  | 415    |  | 1,000  |  | 1,415   |  | 3,000  |  | 1,415    |  | 3,000  |  |
| Direct Expense        | 406                        |  | 523   |  | 406   |  | 523    |  | 406    |  | 523    |  | 406     |  | 523    |  | 406      |  | 523    |  |
| Premium/Tax           | 456                        |  | 573   |  | 721   |  | 1,123  |  | 821    |  | 1,523  |  | 1,821   |  | 3,353  |  | 1,821    |  | 3,353  |  |
| TOTAL                 | (2.2)                      |  | (2.8) |  | (3.6) |  | (5.6)  |  | (4.1)  |  | (7.6)  |  | (9.1)   |  | (17.6) |  | (9.1)    |  | (17.6) |  |
| (% of Income)         |                            |  |       |  |       |  |        |  |        |  |        |  |         |  |        |  |          |  |        |  |
| \$50,001<br>(99.3%)   | 50                         |  | 50    |  | 315   |  | 600    |  | 415    |  | 1,000  |  | 1,415   |  | 7,500  |  | 1,415    |  | 7,500  |  |
| Direct Expense        | 406                        |  | 1,684 |  | 406   |  | 1,684  |  | 406    |  | 1,684  |  | 406     |  | 1,684  |  | 406      |  | 1,684  |  |
| Premium/Tax           | 456                        |  | 1,734 |  | 721   |  | 2,284  |  | 821    |  | 2,684  |  | 1,821   |  | 9,184  |  | 1,821    |  | 9,184  |  |
| TOTAL                 | (0.9)                      |  | (3.4) |  | (1.4) |  | (4.5)  |  | (1.6)  |  | (5.3)  |  | (3.6)   |  | (18.3) |  | (3.6)    |  | (18.3) |  |
| (% of Income)         |                            |  |       |  |       |  |        |  |        |  |        |  |         |  |        |  |          |  |        |  |

1/ FY 1976 estimates.  
2/ Cumulative percent of families with incomes below this level, 1970.  
3/ The NHISA premium is the composite premium per employee in 1976 dollars. The MLI tax is the surcharge on the personal income tax for a family of four. This table does not include the shift from the effect of the elimination of the Medicare payroll tax and the compensating increase in the personal income tax.  
4/ Annual medical expense refers to expenditures for covered services under both NHIPA/Medicare and MLHI. Since the benefit package under MLHI is more extensive than that of NHIPA, a family is more likely to incur expenditures that would not be covered under NHIPA but would be covered under MLHI.

payment of the entire \$600. Thus, in order to have MLHI coverage, the family would have to pay between \$695 and \$2284, depending on their income. At this medical expense level, the total financial burden in comparison to income of both NHISA and MLHI is within 2 percent for incomes up to \$20,000. Because of the higher tax surcharge, MLHI coverage becomes slightly more expensive above \$20,000.

A family that incurs \$1,000 in medical expenses, average for a family of four, would have a direct expense of \$415 under NHISA and a total expense of \$821. Families with incomes below \$10,000 would have exceeded their deductible under MLHI, so some benefits would be paid, while those above \$10,001 would be required to pay the entire expense. At this expense level, MLHI costs 2-3 percent more of income than NHISA. The one important exception is the case of the lower income families where MLHI and NHISA would impose the same financial burden.

The major advantage of MLHI occurs when catastrophic expenditures of \$15,000 are considered. The NHISA direct expenditure is \$1,415 plus the premium of \$406, or a total cost of \$1,821 for all families. For lower middle-income families (\$6001), this constitutes 30.3 percent of income. At the \$10,000 income levels the percent falls to 18.2 percent. MLHI avoids just this inversion because of its income-related cost-sharing. Including the tax surcharge, expenses rise from 13.5 percent to 18.3 percent.

In summary, this comparison demonstrates that at all expense levels, MLHI imposes a smaller financial burden as a proportion of income for low-income families. At higher income levels and for moderate expenses both plans are quite similar, but at high expenses MLHI is superior for families under \$10,000 with NHISA having the advantage at higher incomes.

Comparison of MLHI and FHIP--Table 4 compares the impact of the four expense levels on all classes of FHIP eligible families under both MLHI and FHIP, making the assumption that all expenses incurred were reimbursable under both programs. The MLHI/FHIP comparison is made by income class since both plans fix premium and maximum direct expense on that basis. Table 4 is presented in the same way as Table 3, so direct expenses, premiums, total cost and its percent of income can be easily identified.

FHIP Class 1 families would face no cost-sharing or premium on expenses up to the maximum of \$5,000 but would not have catastrophic coverage. Under MLHI, the Class 1 family faces a maximum of \$144 in cost-sharing and a \$13 tax surcharge with a maximum liability of 5.2 percent of income. The real advantage of MLHI is for expenses of more than \$5,000, where FHIP covers nothing above that level, and MLHI covers all.

TABLE 4  
COMPARISON OF TOTAL COSTS AND BENEFITS OF FHIP AND MLHI  
Family of 2 Adults, 2 Children

| FAMILY INCOME          | ANNUAL MEDICAL EXPENSES 4/ \$50 |       |       |       | \$600  |        |        |        | \$1,000 |        |        |        | \$15,000 |        |        |        |
|------------------------|---------------------------------|-------|-------|-------|--------|--------|--------|--------|---------|--------|--------|--------|----------|--------|--------|--------|
|                        | FHIP                            | MLHI  | FHIP  | MLHI  | FHIP   | MLHI   | FHIP   | MLHI   | FHIP    | MLHI   | FHIP   | MLHI   | FHIP     | MLHI   | FHIP   | MLHI   |
| \$2,999 (FHIP Class 1) | Direct Expense                  | 0     | 10    | 0     | 144    | 0      | 144    | 0      | 144     | 0      | 144    | 0      | 144      | 0      | 144    | 144    |
|                        | Premium/Tax 2/                  | 0     | 13    | 0     | 13     | 0      | 13     | 0      | 13      | 0      | 13     | 0      | 13       | 0      | 13     | 13     |
|                        | TOTAL                           | 0     | 23    | 0     | 157    | 0      | 157    | 0      | 157     | 0      | 157    | 0      | 157      | 0      | 157    | 157    |
|                        | (% of Income)                   | (0)   | (0.7) | (0)   | (5.2)  | (0)    | (5.2)  | (0)    | (5.2)   | (0)    | (5.2)  | (0)    | (5.2)    | (0)    | (5.2)  | (5.2)  |
| \$3,499 (FHIP Class 2) | Direct Expense                  | 0     | 10    | 60    | 120    | 60     | 120    | 60     | 144     | 60     | 144    | 10,060 | 144      | 10,060 | 144    | 144    |
|                        | Premium/Tax                     | 25    | 30    | 25    | 30     | 25     | 30     | 25     | 30      | 25     | 30     | 25     | 30       | 25     | 30     | 30     |
|                        | TOTAL                           | 25    | 40    | 85    | 150    | 85     | 150    | 85     | 174     | 85     | 174    | 10,085 | 174      | 10,085 | 174    | 174    |
|                        | (% of Income)                   | (0.7) | (1.1) | (2.4) | (4.2)  | (2.4)  | (4.2)  | (2.4)  | (4.9)   | (2.4)  | (4.9)  | (288)  | (4.9)    | (288)  | (4.9)  | (4.9)  |
| \$3,999 (FHIP Class 3) | Direct Expense                  | 50    | 25    | 110   | 300    | 110    | 300    | 110    | 360     | 110    | 360    | 10,110 | 360      | 10,110 | 360    | 360    |
|                        | Premium/Tax                     | 50    | 44    | 50    | 44     | 50     | 44     | 50     | 44      | 50     | 44     | 50     | 44       | 50     | 44     | 44     |
|                        | TOTAL                           | 100   | 69    | 160   | 344    | 160    | 344    | 160    | 404     | 160    | 404    | 10,160 | 404      | 10,160 | 404    | 404    |
|                        | (% of Income)                   | (2.5) | (1.7) | (4.0) | (8.6)  | (4.0)  | (8.6)  | (4.0)  | (10.1)  | (4.0)  | (10.1) | (254)  | (10.1)   | (254)  | (10.1) | (10.1) |
| \$4,499 (FHIP Class 4) | Direct Expense                  | 50    | 25    | 159   | 300    | 199    | 300    | 199    | 360     | 199    | 360    | 10,589 | 360      | 10,589 | 360    | 360    |
|                        | Premium/Tax                     | 75    | 59    | 75    | 59     | 75     | 59     | 75     | 59      | 75     | 59     | 75     | 59       | 75     | 59     | 59     |
|                        | TOTAL                           | 125   | 84    | 234   | 359    | 274    | 359    | 274    | 419     | 274    | 419    | 10,664 | 419      | 10,664 | 419    | 419    |
|                        | (% of Income)                   | (2.7) | (1.8) | (5.2) | (7.9)  | (6.0)  | (7.9)  | (6.0)  | (9.3)   | (6.0)  | (9.3)  | (237)  | (9.3)    | (237)  | (9.3)  | (9.3)  |
| \$4,999 (FHIP Class 5) | Direct Expense                  | 50    | 38    | 315   | 450    | 415    | 450    | 415    | 540     | 415    | 540    | 11,415 | 540      | 11,415 | 540    | 540    |
|                        | Premium/Tax                     | 100   | 74    | 100   | 74     | 100    | 74     | 100    | 74      | 100    | 74     | 100    | 74       | 100    | 74     | 74     |
|                        | TOTAL                           | 150   | 112   | 415   | 524    | 515    | 524    | 515    | 614     | 515    | 614    | 11,515 | 614      | 11,515 | 614    | 614    |
|                        | (% of Income)                   | (3.0) | (2.2) | (8.3) | (10.4) | (10.3) | (10.4) | (10.3) | (12.2)  | (10.3) | (12.2) | (230)  | (12.2)   | (230)  | (12.2) | (12.2) |

1/ FY 1976 estimates.

2/ The MLHI tax is the surcharge on the personal income tax for a family of 4. This table does not include the shift from the effect of the elimination of the Medicare payroll tax and the compensating increase in the personal income tax. FHIP premiums are stated in the bill for each income class.

3/ This assumes a maximum FHIP reimbursement of \$5,000 per family which is accounted for by a mixture of the 30-day hospital limit and outpatient benefits payable to each member.

TABLE 4 (Continued)  
COMPARISON OF TOTAL COSTS AND BENEFITS OF FHIP AND MLHI <sup>1/</sup>  
Family of 2 Adults, 2 Children

<sup>4/</sup> Annual medical expense refers to expenditures for covered services under both NHIPA/Medicare and MLHI. Since the benefit package under MLHI is more extensive than that of NHIPA, a family is more likely to incur expenditures that would not be covered under MLHI.

For each of the other FHIP classes, the table can be used in the same way. FHIP provides slightly less cost-sharing than NHISA for families with expenses below \$1,000. Again the real value of MLHI is where expenses are high as illustrated.

#### Comparison of MLHI and Medicare

Under NHIPA, Medicare would be retained for the over 65 population. In Table 5, two income levels were chosen for comparison, \$3,001 and \$10,001, with the same expense levels as for the other comparisons. This table shows the clearest comparison between the two plans. For the low-income aged MLHI is clearly superior at all expense levels, while at high incomes for less than catastrophic expenses, the reverse is true. For example, at an expense level of \$1,000 a family with \$3,001 under MLHI would pay \$174 or 5.7 percent of their income for medical expenses. Under Medicare, the \$140 Part B premium plus \$183 in direct expenses totals \$323 or 10.7 percent of income. At a family income of \$10,001, total Medicare expenses are still \$323, but as a percent of income it falls dramatically (10.7 percent to 3.2 percent). For MLHI the opposite occurs with a \$10,000 income family responsible for the full \$1,000 plus a surtax of \$207. Together their total medical expenses rise to 12.1 percent of income. At the very high medical expense level of \$15,000 MLHI is superior at both income levels.

TABLE 1/  
COMPARISON OF TOTAL COSTS AND BENEFITS OF MEDICARE AND MLHI  
Couple

| FAMILY<br>INCOME | ANNUAL MEDICAL EXPENSES 4/ |       | \$50     |        | \$600    |        | \$1,000  |         | \$15,000 |      |
|------------------|----------------------------|-------|----------|--------|----------|--------|----------|---------|----------|------|
|                  | MEDICARE                   | MLHI  | MEDICARE | MLHI   | MEDICARE | MLHI   | MEDICARE | MLHI    | MEDICARE | MLHI |
| \$3,001          | Direct Expense 3/          | 50    | 10       | 171    | 120      | 183    | 144      | 2,878   | 144      |      |
|                  | Premium/Tax 4/             | 140   | 30       | 140    | 30       | 140    | 30       | 140     | 30       |      |
|                  | TOTAL                      | 190   | 40       | 311    | 150      | 323    | 174      | 3,018   | 174      |      |
|                  | (% of Income)              | (6.3) | (1.3)    | (10.3) | (4.9)    | (10.7) | (5.7)    | (100.5) | (5.7)    |      |
| \$10,001         | Direct Expense             | 50    | 50       | 171    | 600      | 183    | 1,000    | 2,878   | 1,250    |      |
|                  | Premium/Tax                | 140   | 207      | 140    | 207      | 140    | 207      | 140     | 207      |      |
|                  | TOTAL                      | 190   | 257      | 311    | 807      | 323    | 1,207    | 3,018   | 1,457    |      |
|                  | (% of Income)              | (1.8) | (2.6)    | (3.1)  | (8.1)    | (3.2)  | (12.1)   | (30.1)  | (14.6)   |      |

1/ FY 1976 estimates.

2/ Direct expense for Medicare expenditures (except for \$50) were assumed to be appointed 80% hospital and 20% ambulatory. Current Medicare cost sharing was used to calculate the direct expense.

3/ Medicare Premium for a couple is the S.M.I. premium for each person (\$5.80 per month). The MLHI tax is the surcharge on the personal income tax for a family of four. This table does not include the shift from the effect of the elimination of the Medicare payroll tax and the compensating increase in the personal income tax.

4/ Annual medical expense refers to expenditures for covered services under both NHIPA/Medicare and MLHI. Since the benefit package under MLHI is more extensive than that of NHIPA, a family is more likely to incur expenditures that would not be covered under NHIPA but would be covered under MLHI.

### Special Population Groups

At the heart of the MLHI plan is the proposition that all families should be treated equally with respect to their health insurance protection, except to the extent that their health expenses and their ability to meet such expenses vary. While this philosophy is worth preserving, one must recognize that two population groups--the aged, and the non-aged poor--require special attention to insure that their unique problems are adequately addressed.

The Aged -- The average or expected value of out-of-pocket costs for a couple covered under Medicare in 1970 was roughly \$260 per year (\$130 per person). These expenses include SMI premiums, and basic Medicare deductibles and copayments. To make a rough comparison we estimate that if a couple had been under MLHI in 1970, their income would have had to have been greater than \$5,000 in 1970 to have \$260 in average out-of-pocket expenses. In other words, on average, the breakeven income level where the financial risks to a couple are about the same in the two plans would have been about \$5,000 in 1970. The breakeven for a single aged person would have been about \$4,000. Under MLHI about 50 percent of the aged, the poorer ones, would have been better off.

In terms of medical expenses, MLHI is preferable for those aged who utilize relatively little health care in a year or who suffer a prolonged and expensive illness. As previously indicated, Medicare now limits the maximum number of hospital days and increases cost-sharing requirements for the largest stays covered.

Other than the problem of making some persons worse off, which is probably inherent in any new proposal, we also have the "contributory" issue which arises in Medicare. That is, some would say that Medicare is an "earned right" and cannot be taken away. This is a transitional issue; if the basic concept of MLHI is accepted, we may need to develop a way of making a smooth transition without incurring heavy criticism of either MLHI or Social Security. At this time, we can only suggest some options for dealing with this problem.

- o allow those eligible or approaching the eligible age the choice of MLHI or Medicare (essentially a "grandfathering" mechanism).
- o alter Medicare over a period of five years until the benefits and financing are similar to MLHI and then integrate the systems.



- o use the trust fund to reimburse individuals for taxes paid in since 1966--no one has paid in more than \$300 for health insurance. (This responds to the money's worth argument.)
- o adopt MLHI saying it more closely meets our national objective and that transitional problems always result from big changes.

The Poor -- The use of preventive care, early diagnosis, and early treatment have been shown to improve the health status of the individual and reduce subsequent utilization of expensive curative and treatment-oriented medical care. But for the poor, a number of special problems confound their attempts to use such medical services:

- o Low-income is frequently associated with unhealthful living conditions (e.g., poor housing, insufficient nutrition) which make the poor more illness-prone than the non-poor, restricting their ability to participate in the labor force as they get older.
- o The poor are much sicker than the non-poor, suffering from excess rates of chronic illnesses, higher infant mortality and adult death rates, and higher rates of immunizable and communicable diseases. The 1969 U. S. Health Interview Survey, for example, noted that 40.2 percent of people between the ages of 45-64 who earned less than \$3,000 per year suffered from an activity limiting chronic illness; while only 12.1 percent of the same age group for those earning over \$15,000 per year suffered comparable limiting illnesses.
- o The combination of low-income, unhealthful environments and inappropriate health behavior channel the poor into the chronic illness treatment and curative sectors of the medical care system. These kinds of medical care are also the most expensive.

- o When healthy, the poor do not usually seek or receive preventive health care, early diagnostic or early treatment care.

These facts demonstrate that the poor do not receive adequate amounts of preventive, early diagnostic and treatment care and this contributes to their excessive use of expensive curative and inpatient medical care.

The MLHI program can rightly be criticized as a program which by allowing the poor to make choices on how or whether to spend their first health care dollars will further reinforce their tendency not to seek preventive medical care, but to wait until they are demonstrably ill and can get the largest proportion of their medical care costs paid for. But to expect to impact substantially on this problem by simply manipulating the financial aspects of health care is to miss the lessons of the past. Experience under Medicaid demonstrated that even when such services are free, large numbers of the poor continue not to seek and use preventive types of medical care. Even the Neighborhood Health Center programs which are geared to providing such service have only been able to induce a relatively small proportion of the potential population they serve to use such care.

If, as is generally believed, the benefits to both the individual and society from the use of preventive and early diagnostic care are great, then perhaps some combination of financial incentives and stronger non-financial pressures are necessary. Three such possible options are listed below:

1. Tie existing non-health benefit programs for the poor to utilization of preventive care, early diagnosis and early treatment. For example, welfare payments could be made conditional upon utilization of maternal and child health care, immunizations, cancer detection programs, and other early detection programs.
2. Absorb coverage for mandatory preventive, early diagnostic and early treatment care into MLHI, covering first dollar costs, only for a specified range of services.
3. Include coinsurance under options 1 and 2, in order to insure selection of the most economically available mandated services.

#### Arguments Against MLHI

Some of the arguments against MLHI have already been considered, particularly its potential high Federal cost. Here we shall take up for extended comment several other criticisms. These include: (1) MLHI would provide incentives for very expensive treatment, and escalate the costs of medical care; and (2) MLHI would provide little or no leverage on the delivery system, particularly as it relates to the encouragement of health maintenance organizations.

Emphasis on Expenses Treatment -- Catastrophic insurance is criticized for creating incentives for the development and use of very expensive methods of treatment, of benefiting only a tiny proportion of the population, and of encouraging extension of life in medically marginal cases at the expense of using limited resources elsewhere. It is important to distinguish several types of effects.

Prior to old age, a catastrophic health expense is a rare event, so that only a small minority of persons is actually receiving benefits. Despite this, all covered individuals benefit from the risk protection provided by catastrophic coverage. Today access to care in catastrophic cases is hit-and-miss, with personal financial means a major determinant. Equal access for all groups necessarily implies that the use of services will increase in these expensive cases.

In old age, the prospect of major health expenses increases. A significant proportion of the aged population can expect their lives to be prolonged because of care, often very costly, received for chronic conditions. In broadest terms, the social questions is to what extent are health care resources usefully devoted to the extension of life (with the cost of each added year constantly increasing) when there are competing uses for those personnel and facilities.

It is sometimes suggested that a national catastrophic insurance plan should not be adopted because it would increase the use of resources for just that purpose. This argument notwithstanding, private insurance and Medicare are moving rapidly in the direction of extending life. Private plans covering 365 hospital days per year, and plans with maximum benefits of \$50,000-\$250,000 are spreading. Today, for example, 72 percent of Blue Cross subscribers have hospital coverage for 120 or more days of care, and 90 percent are covered for hemodialysis. With the inclusion of renal dialysis

as a disabling condition covered under Medicare, there is the prospect of periodic inclusion of "dread diseases" into public insurance.

MLHI would systematically cover all types of illness resulting in catastrophic expense, providing protection in accordance with ability to pay, avoiding the piecemeal, dread disease approach. By incorporating a small amount of cost-sharing for large bills, some financial incentives for patients and physicians to use resources sparingly can be retained within an overall maximum liability concept.

A separate concern is the dynamic effect of increased funding for high-cost illnesses. Will not medical science increase the rate at which new, high-cost treatments are discovered and made generally available? Doesn't such funding mean more super-specialities of greater complexity and training cost? These are possibilities, but not certainties.

A substantial amount of the basic research and development in biomedicine and health services delivery is Federally-funded. Some degree of control could be entertained over areas of research, emphasizing, for example, preventive methods rather than organ transplants. Furthermore, developmental efforts in those treatments that are currently high can frequently result in major cost reductions.

In addition to these measures, direct controls over utilization are most appropriate for both rare and chronic high-cost treatments. This issue is best confronted by establishing a Review Commission which would make basic decisions about when an experimental treatment has reached both the medical and economic level of development to be reimbursable under catastrophic insurance. The Commission should also set standards of eligibility for life-and-death types of cases on medical/ethical grounds. This is undoubtedly agonizingly difficult, but it seems preferable to today's system of decisions based largely on personal wealth.

The issue, in one form, is whether it is acceptable, and desirable, to remove personal financial circumstances completely from the determination of access to high-cost health care. Is it preferable to retain some cost-sharing, or benefit limits, with the result that less affluent families will have their use limited because of personal expenses?

Improving the Health Delivery System -- Since most health care in the U.S. is supplied in private markets, the financial terms of health insurance can have important effects in allocating health resources and influencing patterns of care. For example, the coverage of only inpatient services has emphasized the growth of hospital-based medical practice. In addition to reordering insurance reimbursement so as to have a neutral impact on methods of providing care, some proponents of national health insurance would use the reimbursement mechanism itself, or the establishment of national insurance standards, to promote and regulate changes in the health delivery system.

There are several important areas of possible Federal action, including:

- o development of peer review procedures by providers (Professional Standards Review Organization, licensure and certification boards, etc.)
- o promotion of quality, utilization and price review mechanism by third-party payors (private insurers and Federal insurance)
- o improvement of audit procedures in Federal insurance programs
- o establishment of fee and price schedules for hospitals and physicians.

While action in any of these areas may be included in insurance legislation, it should be regarded as logically separate from the question of insurance and financing. Similarly, the Federal role in promoting development of Health Maintenance Organizations should be considered as a part of institutional support and capacity-building. The Federal insurance reimbursement mechanism, designed to pay predominantly fee-for-service providers, should provide for neutral treatment of HMO's. To that end, a payment schedule should be designed to provide the actuarial value of the communities catastrophic experience for those individuals who choose to receive care through an HMO.

There is real concern by many that if a family chooses to self-insure for the entire or major portion of those expenses not covered under MLHI, it will attempt to cut down its nonemergency medical expenses--particularly preventive maintenance care. In so doing, the argument

goes, not only will the family face higher medical bills in the future, but it will seriously reduce the incentive to join an HMO. We have already discussed this problem for the poor, but it should also be recognized as a legitimate problem for most Americans.

But whether it is a problem which can be solved through simply lowering the cost of preventive care is another matter. We have argued in another section that if the benefits of early diagnosis and protective care are as clear cut as many health experts believe, a much more comprehensive consumer/health education drive is needed. It may even be necessary to require certain types of preventive care to be used before an individual can be eligible for MLHI. Actions such as this are often used before a child can begin a school year. This is a rather drastic step and should not be undertaken until more information is available about the efficiency of preventive health care. As a first step, however, more widespread consumer health information is needed to better explain to the individual how to use the medical system efficiently.

## STUDENT ASSISTANCE

### Introduction and Summary

The fundamental premise of this paper is that a freer play of market forces will best achieve Federal objectives in post-secondary education. These objectives are greater individual opportunity, the training of needed manpower, reform and efficiency in the way education is provided and a better match between educational programs and individual needs.

Since students have a large stake in each of these objectives, student market choices will, with rare exceptions, be coincident with Federal goals. Students will tend to allocate student aid resources placed in their hands among the institutions and programs which achieve these objectives most efficiently. Accountability through student choice will, accordingly, make institutions and programs accountable to the national interest.

In contrast, institutional or categorical aid to higher education tends to promote the common-denominator interests of faculty and professional guilds. No system of accountability for institutional and categorical aid has been devised which restrains this tendency to any substantial degree. Moreover, institutional and categorical aid programs have a strong tendency to outlive their usefulness. Whereas student choices respond rapidly to changes in the labor market, educational programs cushioned by traditions of Federal categorical support do not.

There will sometimes be occasions when it is in the interest of capacity building to overrule the play of market forces. For example, if we found that too few promising behavioural scientists were interested in educational research in comparison with the social benefits accruing from that research, then special fellowships to recruit talented people might be an appropriate Federal lever. A discussion of criteria for sometimes biasing market choices using such levers appears in the paper on manpower programs. We believe, however, that these cases are exceptional and that the criteria should be stringent.

Accordingly, this paper describes what we should do to give individuals the general power of choice in the education market place, and proposes levels and types of student support which will make most institutional aid programs unnecessary. It proposes three (and only three) non-categorical student aid programs:



- (1) Basic grants, a program of redistributive aid,
- (2) Guaranteed loans, a program on non-redistributive aid, and
- (3) Matching grants to States to induce them to devote a larger share of their higher education budgets to student aid.

All three of these programs are currently authorized but all three are in need of legislative modification:

- (1) Basic grants should be modified to require a student to meet an increasing share of his costs from resources other than grants:
  - (a) as family income increases,
  - (b) as he chooses a more expensive education program, and
  - (c) as he progresses through successive years of college.
- (2) Guaranteed loans should be covered by premium-financed insurance which would pay all or part of a borrower's scheduled repayments if his income fell to levels which would make full repayment extremely burdensome. Such insurance would make greater reliance on loans to finance higher education less of a risk to individual students. The standard loan repayment period should be extended to fifteen years from the present ten and cumulative limits on borrowing should be raised to \$10,000 for undergraduates and \$20,000 for graduate and professional school students.
- (3) The Federal/State matching ratio under the recently enacted State incentive grant program should be reduced from one-to-one to one-to-four and States should be required to permit their students to use such grants at out-of-State institutions.

All other existing or authorized higher education programs would be cashed out with the following exceptions:

- (1) Full cash-out of work-study would be postponed until the youth labor market is more fully developed. Until then, it would be funded on a project grant basis under a market development rationale.
- (2) A few small categorical manpower programs would be funded under stringent criteria for over-ruling market choices, as discussed in the Manpower paper.
- (3) Other capacity building programs would be phased out as explicit market development objectives are achieved. E.g., Upward Bound would be retained, but only so long as it shows potential for demonstrating ways to increase the academic motivation of minority students.

## II. Rationale for a Grant-Loan Mix

Both grants and loans for education create human capital. From the point of view of aggregate economic or social returns, we do not know whether the nation as a whole is investing too much or too little in the kind of human capital created by post-secondary education. The fact that we do not know is itself important. It means that we can and should generally leave decisions about investments in post-secondary education to individuals themselves. This argues for relying at the Federal level as much as possible on improved student loan programs to finance higher education, assuming that the States continue to support higher education at roughly the present level. Grants exclusively for higher education necessarily favor it over the other kinds of investment and consumption. Unsubsidized loans do not, because the student pays for educational opportunities in the same coin he pays for other things. Unsubsidized loans therefore are the preferred Federal instrument in our present circumstances.

There are undoubtedly social benefits stemming from investments in higher education, but that does not mean that it should be subsidized across the board by the Federal Government. It seems likely that private returns anticipated by most students are sufficiently motivating that the social benefits will be produced without additional incentives. There is one glaring exception to this, and it is the basis for having a grant program as well as a loan program. People who have been isolated by cultural differences or economic deprivations do tend to underinvest in higher education from the point of view of having a society with more mobility, more representation of minority cultures and a strengthened common culture. The objective of enhancing incentives to such investment is the strongest rationale for a basic grants program under present conditions.

Apart from such social benefits, we might well want to "cash-in" redistributive student aid for augmented levels of income maintenance. There is no reason why, on grounds of equity alone, that one individual should receive a valuable education voucher and another individual receive no equivalent benefit because he does not choose to continue his education. Low family income is the best criterion we have for awarding grants, but this is because it tends to indicate a tendency to underinvest in education, not because grants serve to even-up income. There is probably no way to dispense grants which does not favor talented and relatively well prepared individuals from low income brackets, thereby increasing prospective inequalities in income.

However, even fairly low income students can be expected to meet part of their educational costs through loans. Many do so willingly even now. Federal policy should be aimed at achieving the right "mix" of grants and loans. Consistently with what has been said before, the share of student expenses met by loans, work or family resources should increase as income increases. There are two additional factors that should affect the mix:

- (1) Cost of attendance. Even if the difference in public subsidy between public and private higher education were reduced as proposed later in this paper, differences in real cost for different kinds of programs would continue. There is "horizontal equity" in expecting a student who chooses a high real-cost option to meet the added costs from loans. Further, the fact of his making such a choice argues for greater willingness to invest appropriately in higher education. We propose that a student's Federal grant should be the same at high cost and low cost institutions, and that the proportionate share of costs met through borrowing, work or family resources be greater at high cost colleges.
- (2) Level of education. The rationale for a grant program is stronger in the earlier years of the student's post-secondary education than in the later and post-graduate years. Both the self-confidence and the actual prospects of a disadvantaged student, though they may have been poor when he started college, should improve as he progresses successfully through his college career. Accordingly, he can be expected to rely little on loans in his first year. But by his last year, and certainly by the time he enters graduate school, he can be expected to rely mainly on loans as an alternative to work and family resources, if loan funds are available on the terms to be outlined later in this paper. We propose that the amount of the maximum non-categorical Federal grant decline over the undergraduate years, reaching zero by the time the student enters graduate school.

The following legislative modifications to the Basic Grants program would achieve a better grant-loan mix along the above lines:

- (1) The half-of-cost/half-of-need limitations should be eliminated. These limitations have the effect of favoring the student who chooses a high-cost option over others with equally low family income. These limitations also have the effect of requiring substantial borrowing in the first year of college if other resources are unavailable, and greater amounts the lower the family income.
- (2) With each year of post-secondary education completed, a "presumed loan amount" would be added to the student's expected family contribution for the following year. These amounts would increase by \$400 steps: \$400 for the Sophomore year, \$800 for the Junior year and \$1,200 for the Senior year.

With these changes the amount of a student's basic grant would be whichever is less:

- (1) \$1,400 less family contribution and presumed loan;
- (b) Cost-of-attendance less family contribution and presumed loan

with the proviso that no grant would be paid amounting to less than \$200. Because of the \$1,200 presumed loan amount for fourth-year students, no college senior would receive a grant unless the \$200 minimum is repealed or unless the \$1,400 maximum is increased. Our preliminary estimate is that the proposed grant-loan mix rules would permit one or the other of these steps to be taken within the Department's budget request, but this estimate is not firm.

### III. Mutualizing the Risk Assumed by Student Borrowers

Even though we are assuming here that the nation as a whole is not underinvesting in higher education from the point of view of aggregate economic returns, individuals clearly often do underinvest, given the higher incomes they could earn with additional education. These cases are often strongly urged as a basis for providing redistributive student aid to middle class students even though there would be few social returns in terms of greater social mobility and similar benefits.

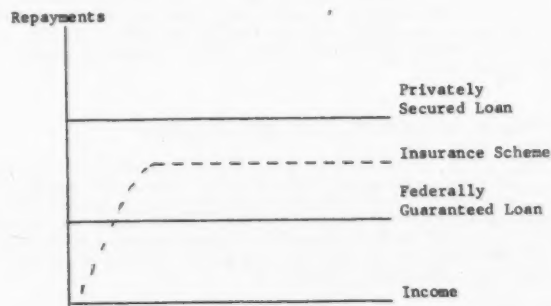
Such individual underinvestment is much more appropriately dealt with through improving capital markets than through redistributive aid. The cause of such underinvestment is the wish to avoid risk, and shifting risks is something capital markets can be made to do well.

The deterring risks to an investment in education stem from the fact that people are uninformed about the prospective returns from pursuing different careers. The best information available is none too good. Further, many people miscalculate their chances of completing training and competing successfully in a chosen field.

These risks can be mutualized through a Federal program of insurance against repayment obligations it would be difficult to meet out of a small income. It has often been argued that risks like these cannot be "insurable" because of adverse selection (people with good prospects opting out) and disincentives to work (not working being like burning down the barn to collect the insurance).

However, the Federal Government is in a unique position to sponsor "insurance" properly so-called. The fourteenth amendment and the bankruptcy laws prevent individuals from mortgaging their human capital. As a result, it is necessary to provide a government guarantee on student loans, simply as a matter of perfecting capital markets. This guarantee, necessary in any case, can be made to do double duty. A Federal guarantee lowers the interest rate on an educational loan below what it would be even if it were well secured. This means that a premium for insurance against risks of educational investment can be added to the interest charge without driving low risk borrowers out of the system through adverse selection, even if they have collateral for a privately secured loan.

The following diagram illustrates the situation:



Conventional repayment schedules are indicated by the two horizontal lines. The upper horizontal line represents a repayment schedule including interest charges on a loan secured by the borrowers collateral. The lower line represents a repayment schedule including the lower interest charges on a Federally guaranteed loan. The broken line which curves from a point near the origin indicates the repayment obligations net of the insurance benefits proposed here. The flat portion of this line is above the lower horizontal line because an insurance premium is included. So long as this flat portion is below the upper horizontal line adverse selection will not occur. The premium income which results permits the reduced repayments indicated by the curving portion of the line.

The amount of the insurance premium which could be charged with no risk of adverse selection is in the neighborhood of .75%. The risk would probably be slight so long as the premium was less 1.25% because parental collateral is a less than perfect predictor of offspring income, and because the risk of adverse selection in the case of borrowers without collateral is virtually nil even at much higher premium levels.

Preliminary estimates indicate that a premium of roughly .75% on loans repayable in full 15 years after course completion would permit a benefit schedule similar to the following:

| Borrower Income<br>During Repayment<br>Year | Benefits<br>per \$1,000<br>Borrowed | Net Repayment<br>per \$1,000<br>Borrowed | Repayment<br>per \$1,000<br>as % of<br>Income | Marginal<br>"tax" rate<br>per \$1,000<br>Borrowed |
|---------------------------------------------|-------------------------------------|------------------------------------------|-----------------------------------------------|---------------------------------------------------|
| 0 - \$4,000                                 | \$110                               | \$ 0                                     | 0.0                                           | 0.0                                               |
| 4,000 - 5,000                               | 95                                  | 15                                       | .3                                            | 1.5                                               |
| 5,000 - 6,000                               | 80                                  | 30                                       | .5                                            | 1.5                                               |
| 6,000 - 7,000                               | 65                                  | 45                                       | .7                                            | 1.5                                               |
| 7,000 - 8,000                               | 50                                  | 60                                       | .8                                            | 1.5                                               |
| 8,000 - 9,000                               | 35                                  | 75                                       | .9                                            | 1.5                                               |
| 9,000 - 10,000                              | 20                                  | 90                                       | .9                                            | 1.5                                               |
| 10,000 - 11,000                             | 0                                   | 110                                      | 1.0                                           | 1.5                                               |

Within the premium constraint benefit schedules could be devised considerably different from the above. Any schedule of roughly this character would, however, meet the following requirements.

- (1) Protection would be provided against the risks of serious miscalculation of academic and financial success.
- (2) Compulsory participation by all borrowers seeking a Federal guarantee could be justified on social insurance principles.
- (3) Disincentives to employment would be slight for total borrowings less than \$10,000.
- (4) Federal budget costs for meeting default claims due to good faith inability to pay would be drastically reduced.
- (5) Husband and wife borrowings and earnings could be pooled in determining benefits.
- (6) Artificial incentives to additional borrowing would not be created since every additional \$1,000 borrowed would increase repayment liability proportionally at all income levels.

The delivery system for handling insurance claims could be extremely simple. Borrowers would make repayments as they came due. If a borrower experienced reduced income in a given year, he would file a claim for benefits at the time he filed his Federal income tax return for that year. A simple table would indicate for each adjusted gross income bracket the percentage of repayments regularly scheduled which would be offset by a payment from the insurance fund. The borrower would mail his claim form, it would be compared with his tax return, and a check would be mailed to him.

Gearing the system simply to adjusted gross income without regard to elaborate computations of exemptions and deductions would be justified on the rationale that adjusted gross income is the figure that best reflects the rate of return on the individual's educational investment and it is this rate which the insurance program proposed to stabilize.

This delivery system for insurance benefits should be sharply distinguished from that for default claims. These latter claims would be presented by lenders, not borrowers, just as at present. The problem of guaranteed student loan defaults is largely a management problem beyond the scope of the essentially programmatic reforms discussed here. The insurance against excessive repayment burdens proposed in this paper would reduce defaults attributable to good-faith inability to pay, but would leave the problem of bad faith defaults untouched.

To make the system envisioned here more effective we recommend two additional actions:

- (1) We propose that legislation be sought to extend to fifteen years (from the present ten) the repayment period the borrower may elect. A lengthened period would extend repayments over a larger proportion of the income-producing life of the borrowers educational investment. We propose, however, that a borrower be allowed to choose a shorter period or to prepay his loan without penalty, although a small degree of adverse selection would occur as a result.
- (2) The cumulative statutory limits on borrowing should be amended to permit undergraduates to borrow up to \$10,000 and graduate and professional school students to borrow up to \$20,000.

#### IV. The Survival of Private Institutions

The Federal Government alone cannot guarantee the health of the higher education market place. Even if most Federal resources for higher education are channeled through the market place, as proposed here, responsiveness to market forces will be muted because the far larger resources of the States are channeled almost exclusively to public colleges and universities in the form of institutional support. The result is a pervasive difference between the price of public and private higher education that has nothing to do with either real costs or relative effectiveness. The much lower price of public higher education imparts a major bias to student market choice away from the private sector. In these conditions rational market behaviour can result in the weakening of many private colleges and the closing of some, even when their educational programs and their relative efficiency would entitle them to thrive in a freer market.



Although the States are increasingly concerned with the consequences of the institutional subsidy mechanism, it seems unlikely that they will spontaneously change the system substantially, for three reasons:

- (1) State officials--and many university faculty and administrators--often prefer direct political accountability to accountability through student market choice.
- (2) An important motive for State aid to private institutions is beginning to weaken, namely the wish to channel more students into the private sector in order to avoid large capital outlays for enlarging public institutions. Now that over-capacity within public institutions is becoming pervasive, States will be under less pressure to support places for students in the private sector.
- (3) Permitting students an unprejudiced choice of private and proprietary institutions may mean letting students spend State funds in other States, to the disadvantage of the home State's economy. It may also mean a loss of skilled manpower if the students do not return.

The major incentive now operating on the States towards changing the tuition subsidy system results from legal challenges to residency requirements. Student aid programs might provide States with an alternative to such requirements. For example, a State could plausibly award student aid exclusively to its own high school seniors, avoiding the need to give aid to in-migrants at the time they enroll and establish residency. The lack of State interest in this device suggests the strength of the opposing considerations.

Because the States seem unlikely to make a substantial shift from a tuition subsidy mechanism without extrinsic incentives, a major role falls to the Federal Government. The situation is in many ways the exact opposite of one calling for a "no-strings" revenue sharing strategy. Though the ultimate objectives of State and Federal policy are the same, the States pursue those objectives through allocation mechanisms which are substantially counter-productive. Classic revenue sharing, e.g., turning over Federal student or institutional aid funds to the States with no strings attached, would (disregarding substitution effects) increase the undesirable subsidy differential between public and non-public institutions. The case is one where a set of carefully structured Federal levers may be needed precisely in order to change State policies.

The alternatives to a policy of incentives for shifting State funds to student aid seem inadequate or unacceptable. On the one hand, the Federal Government could seek to improve consumer information about educational programs (e.g., by SEC type disclosure requirements), but this would leave price-differentials

untouched, and might even accelerate the decline of marginal private institutions. On the other hand, the Federal Government might increase the funding of its own student aid programs to levels which made State support unnecessary either in the form of tuition subsidies or student aid. But such a Federalization of higher education costs might lead in the long run to a system even more lacking in variety and choice. It would be difficult for the Federal Congress to resist a temptation to impose non-market accountability rules if the Federal Government assumed most of the huge financial burden of post-secondary education. Therefore, we are left with the options of (1) doing nothing to affect this problem and accepting further undercutting of the private institutions or (2) instituting a program to provide incentives for States to change the mix of resources they allocate to higher education in the direction of more student aid.

While the Congress has not declared itself in favor of a massive shift from tuition subsidies to student aid, the recently enacted State Student Incentive Grant Program represents a policy favoring an incremental shift. This program, by matching State scholarship and loan programs with Federal money, makes it financially advantageous for States to redirect their own appropriations.

There are, however, problems with existing legislative authority. The incentive in the bill is a very powerful one, providing 50% Federal matching for qualifying State student aid programs. Such a rate is almost certainly unnecessarily high to induce change in State support mechanisms. Furthermore, at this matching rate many existing State programs will qualify for their full allotments in the first two years of the program without appropriating new money. <sup>1/</sup>

A Federal matching rate of 20% would probably provide sufficient incentive for funding shifts. At a rate of 20%, the \$50 million initial authorization plus \$150 million in authorized continuation grants would not be fully claimed by the States until they had shifted \$800 million to student aid. Our studies of the sensitivity of student choice to tuition differentials are incomplete, but it seems quite possible that a shift of this magnitude would improve the competitive position of private colleges dramatically.

A second major problem with the enacted legislation is its silence on the question of residency requirements and out-of-State portability of qualifying State student aid. Since State student aid can be used as a vehicle for re-erecting barriers equivalent to the old in-State/out-of-State tuition differentials, and since the State Student Incentive Grant program would stimulate such aid, the Federal Government could find itself a party to

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<sup>1/</sup> This may be due to an error in drafting the bill. The conference committee may have thought they had included a maintenance of effort provision which would require higher levels of State appropriation to qualify for Federal matching.

creating such barriers. Amending the legislation to require that State student aid be portable across State lines would increase the in-State student's options, and would be consistent with the Federal role of increasing market choice.

In the main, however, the approach of the new legislation is consistent with Federal market development purposes. It is noteworthy as a case in which a market development strategy requires large scale transactions with the States. It is, moreover, a case in which substitution effects are positively desirable. That is, the legislation will fail to meet fully its objectives if the States do not regard Federal matching funds as freeing State resources for other purposes.

#### V. Cashing-in Other Federal Student Aid Programs

So far we have proposed three student aid programs which are responsive to Federal roles: (1) a modified basic grants program to secure the social benefits of educational opportunity and (2) a modified guaranteed loan program to develop the human capital market through mutualization of risks of low income, and (3) a modified State incentive grants program to provide incentives for States to place more emphasis on student aid as a vehicle for the support of higher education.

The resources made available by these proposals through the educational market place will permit the cashing-in of many categorical training and manpower programs (now totaling some \$1.2 billion) not meeting the fairly stringent tests for exceptional treatment outlined in the Manpower paper. In other cases we should accept the verdict of the market place. Similarly, institutional aid programs which are disguised forms of long-term institutional and student support should be cash-in or eliminated. There are six major student or institutional aid authorities which are prima facie candidates for cashing-in or elimination:

- (1) The supplemental EOG program. This should clearly be cashed-in in favor of funding a higher Basic Grant maximum. The authority is either redundant or contrary to the concepts of partitioning grant and loan aid described here.
- (2) New interest subsidies commitments on Federally guaranteed loans should clearly be ended and also new Federal capital contributions to NDEA loan funds, which in the long run serve only to provide interest subsidies. Interest subsidies are an extremely imprecise way of overcoming tendencies to underinvest in higher education. The low income student would be much more influenced by a grant

equivalent to the Federal interest subsidy cost. The middle-income student who is worried about assuming a large loan repayment burden would be much better reassured by the kind of repayment insurance we have proposed.

Existing subsidy commitments cannot, of course, be terminated and will continue to burden the Federal budget for perhaps a decade.

- (3) General institutional aid based on student aid factors. This authority should not be funded (unless as an interim measure) since it will be less effective than State incentive grants in dealing with the problems created by tuition differentials, since it cannot be expected to build capacity, and since it may prove merely to be a form of revenue sharing where public institutions are concerned because of substitution effects.
- (4) Dependent student benefits under Social Security (beyond high school) should be cashed out. If an optimal loan-grant mix is chosen and basic grants are funded at a level consistent with this choice, social security benefits would represent an arbitrary bonus for those in a survivor relationship with a social security eligible. We proposed grandfathering present social security beneficiaries with phase-out of new claims beginning in FY 1974 and completed by FY 1977.
- (5) The work-study program. If only WPA-type jobs were at issue, it would be clearly desirable to cash-in the work-study program for a higher basic grant maximum. The basic grant delivery system will be more equitable and predictable. The work done by the student in WPA-type programs is probably counter-productive of real identification with the world of work. However, some colleges have programs in which students receive job assignments of great economic, social and educational value which would not result from the ordinary operation of the labor market because of imperfections in that market affecting all young people (e.g., credentialing, bureaucratization of hiring practices, unions, and lack of performance measures enabling a young person to demonstrate his abilities). We propose that work-study be funded at a level sufficient to sustain the better institutional programs, that the authority be placed on a project grant basis, and phased out when some of the problems of the youth labor market have been solved.

Alternatives would be (a) major emphasis on subsidized employment in cooperative education programs, or (b) a "GI Bill" type program in which students would build up credits for subsequent education while working at off-campus jobs.

- (6) Various special-purpose programs such as Developing Institutions and Upward Bound are potential candidates for cash-out. However, some of these should be retained on capacity building grounds. We propose to address the precise mix in a later paper, and here propose their temporary retention, with cash-out anticipated by 1978.

We do not propose "hold harmless" provisions as such for students and institutions which have depended on forms of aid which would be cashed-out with the single exception of social security student beneficiaries. To make such provision is unnecessary in the case of students, since expanded loan availability would assure that they would be able to complete their educational programs. We believe that the legitimate claims of institutions will be met by (1) capturing student aid through higher charges to students and (2) phase-out of institutional aid on a schedule that makes sense on capacity building grounds alone without a deliberate effort to hold harmless.

For example, the Developing Institutions (Black College) program has been administered as a program of permanent institutional support on which the colleges have come to rely. We should not, however, continue to fund the program for this reason. Rather, clear objectives of capacity building should be defined for these institutions, should determine levels of support and should establish a schedule for moving to termination. A reasonable schedule will allow enough time for the institutions to adjust to greater reliance on student payments without a specific hold-harmless clause.

#### V. The Proposed Federal Role in Higher Education

The proposals outlined in this paper would change the relationship between the Federal Government and higher education substantially. Although the share of Federal support for higher education made available in the form of student aid has been increasing in recent years, most such funding (other than Veteran's and social security benefits) has not been portable to the institution of the student's choice. It has been allocated by methods which, for example, have made it an unreliable support for the Black colleges. Most of it has been unavailable for study at proprietary and technical schools. Market forces have been muted.

With all Federal student aid made fully portable as proposed, and with a significant shift of State funding in favor of student aid, the influence of market forces should become pronounced. Both the guaranteed loan changes proposed and the State incentives would exert a high degree of leverage on other resources without encumbering the Federal budget substantially. Although projected funding for the largest budget item, basic grants, would not change greatly, the resources for which institutions

would compete in the market place would grow dramatically. At the same time, Federal budget costs for institutional aid and categorical manpower programs would be cut back sharply. Except in the research area, the Federal presence in institutional decision making would become much less evident. The claims of higher education for Federal support on either a continuing or emergency basis would be deflected. Decisions about how to create efficient programs meeting student needs at acceptable cost would tend to displace decision making geared to attracting Federal support for institutional aspirations.

## INCOME AND EMPLOYMENT POLICY

### I. INTRODUCTION AND BACKGROUND

The purpose of this paper is to discuss a DHEW proposal for an income and employment policy. This policy is one component of direct financial aid to families and individuals, a primary DHEW function. The other components are student aid and health insurance which are described in separate papers. To provide some background and to set the context for our proposal, this section briefly discusses the general financial aid function.

We suggest that it is useful to think in terms of three systems which provide income support -- employment, social insurance and income assistance -- involving both public and private actions. Sections II, III, and IV deal with each of these three specific areas in turn.

Section IV brings us to welfare reform -- the satisfactory accomplishment of which is of central importance to the overall objectives of the proposal. This must remain one of the highest priorities in the competition for limited Federal resources for domestic concerns. Following a brief discussion of the new Federal program for the aged, blind and disabled, Section IV deals in considerable detail with a possible new approach to family welfare reform -- one which draws on the strength of both H.R. 1 and the Senate Finance Committee's approach.

#### Financial Aid to Families and Individuals

Assistance to individuals is the keystone of the DHEW reform effort because it is through this effort that we attempt to provide for all citizens a basic command over goods and services which most significantly decentralizes decision-making away from the Federal government. This decentralization should greatly simplify the Federal role.



This paper focuses on assistance to individuals in the form of cash--through income maintenance and employment. Logically we must first make some decisions about the extent to which various groups of our population will have command over goods and services in general before we can fully develop voucher and direct service programs to improve access to particular goods.

#### Income and Employment Policy

The central public objective that heavily influences the design of the income maintenance and employment systems under this Proposal is that they must quickly move us toward a minimum standard of adequacy if demands for other, less desirable, forms of public action are to be reduced. If it is not possible to achieve some appropriate level of command over goods-in-general for all, then we can expect to see accelerating pressure for categorical programs to provide specific goods and services.

These systems might be characterized as having two broad functions with regard to income: provision of a basic income floor, and replacement of lost earnings. In order to accomplish these functions, society relies primarily upon three levels of public and private action (the latter two comprise what we mean by our income maintenance system):

- Employment Policy - This policy includes both public and private efforts to promote the possibilities for all potential workers to support themselves and their families entirely on earned income.
- Social Insurance Policy - This is a combination of public and private policies to replace a portion of the wages lost due to unemployment, disability, retirement, and death.
- Income Assistance Policy - This is public policy designed to meet the objective of a minimum standard of adequacy for those who, for various reasons, are not receiving adequate incomes from other sources.

#### II. EMPLOYMENT POLICY

The interrelatedness of the employment system and many of the other problem areas with which DHEW is concerned cannot be over-emphasized.

- It is more desirable to increase income in the form of earnings, or transfers that are related to past earnings, than in the form of income assistance. We may in time somewhat alter our definitions of work, but this is not likely to alter the basic idea that income should be earned if possible.
- Generally speaking, greater employment means greater economic growth and less need for income redistribution to provide minimum standards of command over goods and services in general.
- As the unemployment rate decreases, relatively greater increases in earned income tend to accrue to the lower income groups because low-income workers tend to be at the bottom of the hiring queue. The only significant, lasting shift in income distribution that has taken place in this country in the 20th century occurred during World War II. In fact, the continued high employment rates of World War II resulted in far more improvement in the relative lot of the "disadvantaged" than all the civil rights and manpower program activities of the 60's.
- The fewer the employment opportunities, the greater the burden on both the social insurance and income assistance systems. The higher the levels of employment we can sustain, the more we can rely on social insurance to carry us through relatively slack periods and the less we need rely on income assistance for any but those who have no attachment to the labor force.
- High unemployment tends to make income assistance programs more complex and difficult to administer. If people are readily to substitute work for welfare, jobs must be attractive and available. When unemployment is high, special measures must be taken to insure that individuals pursue work opportunities; these measures may include actual job creation in job-scarce areas.

- Employment may have benefits, in addition to the income it provides, such as its favorable impact on mental health, physical health, delinquency rates, and family stability. Savings may accrue to society by not having to deal in a remedial fashion with difficulties that could have been prevented were more people working.

There is no attempt made here to deal comprehensively with Federal employment and manpower policies since much responsibility for them lies outside of DHEW. In a separate paper on student aid it is proposed that the Federal government, through guaranteed loans (and some scholarships in the case of low-income students), make it possible for all students to finance whatever post-secondary education they desire. And, in the last section of this paper, which is on welfare reform, a proposal is developed in some detail for an employment policy for low-income persons (and families) eligible for Federal assistance. In this proposal, particular emphasis is placed upon policies which affect the demand side of the labor market.

III. SOCIAL INSURANCE

The function of social insurance is to replace wages lost due to unemployment, disability, retirement, or death. Social insurance represents society's back-up system to ease the hardships caused by the abrupt cessation of earned income. An effective national employment policy enhances the role of social insurance in the overall income maintenance system because more individuals have a closer attachment to the labor force, so more are eligible for work related social insurance, and fewer require income assistance when their earnings cease.

An outline of the public and private programs which together comprise the social insurance system is provided directly below, followed by a discussion of the specific programs.

| <u>REASON FOR EARNINGS LOSS</u> | <u>EARNINGS REPLACEMENT PROGRAM</u>  |
|---------------------------------|--------------------------------------|
| <u>Temporary Unemployment</u>   | Unemployment Insurance (UI)          |
| <u>Disability</u>               |                                      |
| Resulting from work             | Workmen's Compensation               |
| Not resulting from work         | Sick Leave                           |
| Short Term                      | Temporary Disability Insurance (TDI) |
|                                 | Private Insurance                    |
| Long Term                       |                                      |
| Total                           | Social Security (OASDI)              |
| Partial                         | Veteran's Compensation               |

Retirement

Low to Middle Income  
Retirees

Social Security (OASDI)  
Some Private Provision  
(pensions, annuities)

Middle to Upper Income  
Retirees

Social Security (OASDI)  
Considerable Private Provision

Death

Life Insurance  
Social Security

Unemployment Insurance

No matter how effective a national employment policy is there will always be persons unemployed, and a strong unemployment insurance (UI) program will be needed. Currently, UI is designed to replace wages lost by the temporarily unemployed by redistributing income from employers and the employed to the unemployed. UI should be designed to play a large role in the income maintenance system in the years to come. IF UI is performing its functions well it will aid in:

- distinguishing the temporarily unemployed and their needs from the needs of the chronically unemployed and the unemployables;
- helping those whose work record has entitled them to UI benefits to remain off income assistance until it is clear that they are experiencing more than temporary disengagement from the labor market; and
- providing incentives to recipients to retain their links to, and re-enter, the work force.

Unemployment Insurance programs, all of which are State administered, are inadequately coordinated with the income assistance system and are not satisfactorily accomplishing the objectives set out above. If the Federal government is going to assume responsibility for a minimum national welfare system then it would be prudent also to ensure that UI programs are operating in a manner that will minimize the need for welfare for the temporarily unemployed. Some minimum national standards might be required, such as:

- uniform job coverage across the nation, extended to include farm and domestic work;
- uniform entitlement that sets a reasonable minimum work period beyond which the individual becomes eligible for UI benefits over the maximum time period (26-52 weeks depending upon unemployment levels in the State labor market); and
- wage replacement rates which are coordinated with the payment levels of the income assistance program.

#### Disability

Disability is one of the most complex areas of social insurance policy, involving a number of public and private programs. We are not prepared at this time to go any further than a few brief comments on it.

- Workmen's Compensation - This is a State-run program to provide wage replacement and medical care to individuals disabled in the course of their work. In July 1972 the National Commission on State Workmen's Compensation Laws reported that currently the protection offered by this system is "inequitable and inadequate." It rejected, however, the idea that the system should be Federalized or replaced by some other mechanism.

One desirable feature of a Workmen's Compensation program is that it should offer powerful incentives for employers to provide a safe working environment for their employees. The Federal role in this program can probably be confined to requiring that minimum standards are maintained which ensure that employers must recognize the environmental cost of their working conditions; the goal should be to prevent the need for more "black-lung" type programs.

- Sick Leave, Temporary Disability Insurance, and Private Disability Insurance - These are all programs that deal with disabilities over the short-term (less than 6 months). About 36% of the earnings lost from short-term disabilities is replaced through some type of plan. Despite the large amount of unreplaced income, it is doubtful that the Federal government should intervene in this problem at this time beyond providing increased incentives for the development of more private replacement.

Long-term Disability - To the extent that long-term disability is total, we have in Disability Insurance (DI) under the Social Security Act a strong Federal program of wage replacement. It is partial long-term disability that is the most perplexing problem in the disability area. The Veteran's Compensation and Workmen's Compensation programs pay benefits for permanent partial disability. However, the considerable discretion allowed decision makers, including agency adjudicators and courts, in determining the extent of disability in these cases has led to such significant variations in payments that the integrity of the entire program has been jeopardized. In view of these difficulties, for which we can offer at present no good solution, our recommendation must be to resist extending the Federal income maintenance role in long term disability cases into the partial disability area. Further analysis of the issue is required before any programmatic steps should be taken.

#### Retirement

The function of replacement of wages lost upon retirement should continue to be shared by OASDI and private provision (mainly private pensions), but it may be desirable to make adjustments to social security that will ensure that it is better coordinated with private pensions. Specifically, we believe that social security should be developed to meet fully the wage replacement requirements of those retirees who have average pre-retirement earnings less than the median. These are the individuals who we cannot expect to be able to save sufficient amounts for retirement purposes and who are often inadequately covered by private pension plans. For retirees who have had above-median wages, social security would continue to be provided, but replacement rates would be lower, and private pensions would be expected to fill the gap.

Beyond the coordination of the wage replacement function with private pensions, we must come to grips with a very basic problem which has been developing in the social security system. Increasingly, social insurance is being asked to perform functions which more legitimately should be accomplished with income assistance. Simple wage replacement should not be expected to solve the income problem of persons whose earning power has always been too low to support their family responsibilities. Thus if complete replacement of recent-year earnings leave a retiree with an inadequate income, supplements should be

provided through the income-tested Supplemental Security Income program, but the wage replacement function of social insurance should not be distorted by special minimums. Our proposal would thus confine social insurance to its wage replacement role.

Below we present some specific alterations we would make in social security in order to enable it over the long run to be a more effective wage replacement system.

- OASDI benefits should be related to recent years' earnings, not to a working-lifetime average.
- The wife's benefit should be reduced from 50% of the husband's benefit to about 33% to more accurately reflect the appropriate differences in living costs between single persons and couples.
- We should maintain current replacement rates (60% for single persons) for low wage workers at approximately their current levels while increasing the replacement rate for median-wage workers to 50%.
- We should resist attempts to raise minimum benefits or add benefits which do not support wage replacement objectives.

The above proposals assume the further expansion of private pension systems for earners above the median. The Federal role should be to encourage this expansion and the expansion of private annuity plans and to set minimum standards that are supportive of private wage replacement system.

Some of the above improvements would require increases in outlays over current law. Our general opinion regarding priorities is that costly changes in OASDI must rank below the much needed reforms of the welfare system. Therefore, we do not propose that any outlay-increasing changes be made in OASDI in the near term.

#### IV.

##### INCOME ASSISTANCE ( Welfare Reform )

The maintenance of relatively full employment over time, coupled with education and manpower policies, should permit most healthy and willing persons to sustain employment which would enable them and their families to remain out of poverty. Social insurance programs, then, should partially replace the earnings of those who



have had a close attachment to the labor force but are unemployed, disabled, retired or deceased. The rates of replacement generally should be sufficient to eliminate the need for income assistance for this population. Finally, income assistance is available to supplement the incomes of those who remain in need. This group will consist primarily of the aged, disabled, and those who have not had a close attachment to the labor force.

If employment and social insurance were performing their functions well, there would be fewer people dependent upon income assistance who have a close attachment to the labor force. However, these systems are not performing adequately, particularly the employment one. There is a need for special manpower and employment policies targeted on these individuals who are employable, along with needed assistance for their families, in order that they might eventually become non-dependent.

There is no need to provide general discussion of the inadequacies of our existing income assistance programs, which have been well documented. Recent legislation has provided for a Federal program for the aged, blind and disabled which is a major step towards adequate coverage. For this reason, we discuss the treatment of this population only briefly below. Welfare reform for families, however, remains the major unresolved issue and is central to the overall objectives of the proposal. Below we detail a possible new approach that benefits from the strengths of both H.R. 1 and the Senate Finance Committee's approach to reform.

#### A. AGED, BLIND AND DISABLED

The new Supplemental Security Income (SSI) program for the aged, blind and disabled which will go into effect in 1974 is one of the bright spots in the income assistance system. Uniform eligibility rules are established; the Federal government establishes minimum payment levels which can be supplemented by States according to their tastes, and the program has income disregards which encourage work. The primary objective of this program is to reduce poverty, and the system allows us to effectively target our funds on the aged poor. One of our recommendations in the section above was to resist using OASDI as a poverty reducing mechanism. Now with SSI there is a more efficient Federal alternative to increases in the so-called "welfare" features of OASDI such as the minimum benefit.

We propose only the following changes in programs for the aged for the near term:

- To preserve the real value of SSI benefits over time, there should be an automatic cost-of-living adjustment. It should operate similarly to, and be synchronized with, the OASDI cost-of-living adjustment.
- When SSI is effective in 1974, those eligible for the program will no longer be eligible for food stamps. We believe also that with the new higher SSI benefits, in addition to the recent liberalizations of social security, the nutrition program for the elderly could be ended. This would reduce yearly outlays by \$100 million.

#### B. FAMILIES

In this section we discuss a possible new approach to welfare reform for families. While it is only one of many alternative approaches that deserve serious consideration, we believe that it contains many aspects which are of sufficient merit to warrant significant attention. This proposal is presented in some detail in order to encourage a well-focused dialogue on this subject. However, the particular values of many of the parameters that are chosen (e.g. the basic benefit level for a family of four) are not crucial to the basic design of the proposed program. For this reason, attention should be focused on those broad areas of difference with H.R. 1 in an attempt to evaluate the extent to which these differences improve upon inadequacies of H.R. 1. The inadequacies we have in mind here are primarily those identified by the Senate Finance Committee.

- The treatment of those available for work was not sufficiently "tough." Only registration with DoL was required in order for an "employable" as well as other family members to receive benefits. This would have been likely to result simply in an extension of the welfare system to many "employables" who are not presently covered, with little increase in their actual work effort.
- The longer run "success" of the program hinged upon a generally inadequate set of work incentives and employment policies. Two examples of this were the high implicit marginal tax rate on earned income and the insufficient attention paid to the general unavailability of jobs for those required to register for work (especially in times of overall high unemployment).

- The Federal minimum benefit levels were too likely to be disruptive in many of the lower income (Southern) States.
- H.R. 1 had many features which would cause difficult and costly administrative problems. Determination of what would constitute an "acceptable" job in the regular labor market was one of them.

The Senate Finance Committee proposal was clearly conditioned by some of the considerations mentioned above. The approach that we formulate is also conditioned by those considerations; however, we believe that it retains many important strengths of H.R. 1. In addition, it results in a system that can be more easily and equitably administered than either H.R. 1 or that of the Senate Finance Committee.

In broad outline the welfare reform proposal detailed in the pages that follow contains the following elements:

- For families with no member who should work, a benefit system similar to that of H.R. 1.
- For families with members who should work, stronger incentives to do so than under H.R. 1. Benefits would be scaled to reflect only the number of family members not available for work; the available person could increase the family's income only by working.
- Large savings through reduced need for manpower services and job creation, and no need for child care, by virtue of classifying as "available" for work only heads of two-parent families and heads of one-parent families with no child under (say) age 15.
- A unified and comprehensive set of manpower services, up-grading subsidies and public service jobs, with strong incentives to take jobs in the regular labor market.
- A provision to permit low-wage States to opt for basic benefit levels below the Federal standard.

#### Families Without Available Members

The differences are minimal in the treatment of families without available members between our proposal and H.R. 1. The basic elements would be:

- . H.R. 1 type Federal benefit levels. We are proposing a level of \$2,700 for a family of four for FY 76 (approximately 65% of the poverty level and, allowing for inflation, the same real levels as H.R. 1).
- . A 50% marginal tax rate on earned income and 100% on unearned income.
- . A provision to take into account assets.

In addition, members of these families would be eligible for the employer tax credit policies discussed below, as well as the other manpower programs if slots are open after availables have been taken care of.

The 50% marginal tax rate is chosen in order to preserve strong positive work incentives. Even though we would not require any of these families' members to work in order to receive benefits, many of them will prefer to work and they should not be discouraged by unnecessarily high marginal tax rates. However, we recognize the high marginal tax rates we speak of are not just the result of the welfare system; they result from marginal rates that are also imposed on some recipients such as the social security tax rate, housing allowance programs and the beginning of the income tax. If, in order to lower the welfare caseload that resulted from our plan, we chose to retain a 67% marginal tax rate, then we should take action to reduce the other marginal tax rates that impinge upon the recipients so the total rate does not exceed 100% under any circumstances.

#### Families with Available Members

It is for these families that the most significant design departures from H.R. 1 occur, primarily because of a stronger work requirement. We propose that no welfare benefits be paid to the family for those members determined available. But total family income, including the earnings of any availables still would condition the size of the grant that the family received. This would be done in a manner similar to that for families without available members with one exception -- the first \$1,800 of income earned by the available member of the family, if he is employed in the regular labor market, would be disregarded. This provides an extremely strong incentive for such work. Earnings above the first \$1,800 would be subject to the 50% marginal tax rate.

Thus for the typical two parent family of four (with benefits of \$900 for the first person, \$900 for the second, \$450 for the third, \$450 for the fourth....) with an available male head, the family would have a basic benefit level established at \$1,800 (\$900 + \$450 + \$450), not \$2,700. No welfare benefits would be paid for the available person. The first \$1,800 he earns in the regular labor market would not result in any reduction in his family's benefits; above that level they would be reduced \$1 for every added \$2 he earned. The breakeven point would be \$5,400 -- the same as for the family of four without an available member.

The program outlined in the previous two paragraphs thus contains:

- . a much stronger push into work for availables, by not paying any welfare benefits for them; and
- . a much stronger pull into the regular labor market by disregarding the first \$1,800 of earnings.

But what of the actual work opportunities that exist in the regular labor market for availables? Most of the availables under our proposal are male heads of intact families who will be holding jobs in the regular labor market entirely through their own efforts, particularly during times of relatively low unemployment. However, there will be many who will need assistance in locating, holding and being upgraded in jobs so that they eventually will have no need for income supplementation. We propose to accomplish this in the following ways:

- . All availables would register with (say) a new Federal administration created for the purpose. Those who hold jobs would be eligible for any necessary work-related supportive services. Those who are, or become, unemployed would be able to benefit from job search, job development and job placement services. Limited training opportunities would also be available when it was known (with a high degree of probability) that jobs requiring this training would be available to the recipients in the local labor market.

None of these measures are new concepts, but by focusing them on a very limited population and by benefitting from all of our previous experience, we should be able to utilize them more successfully.

Unless all labor markets are quite tight, however, the above efforts still will not be sufficient. More attention will have to be paid to the lack of availability of jobs in the regular labor market for all registrants who will need them. Two important measures would help overcome this problem.

- . There would be an employer tax credit, as in the new WIN program, for hiring and retaining on their regular payroll all workers eligible for the Federal program. (In the case of public employers we might consider a direct subsidy of similar magnitude.)
- . There would also be an employer subsidy for upgrading eligible workers. Rather than subsidizing employers for training as present manpower programs do, we would subsidize them only for results -- i.e. salary increases caused by increased productivity.

Both of these policies should be extended to all members of families eligible for Federal assistance and perhaps to low-income unrelated individuals and childless couples, not just to availables.

Finally, for most of those remaining availables who, even with the above set of policies, are not able to locate a job in the regular labor market after some period of unemployment, we would undertake the obligation to offer them a Federally subsidized public sector job. Our ability to do this would vary with the demand for such jobs, which in turn would depend primarily upon aggregate employment conditions, but every effort would be made to make such an offer to the bulk of medium and long term unemployed availables. We would strive for public sector jobs with the following characteristics:

- . They would be socially useful.
- . They would provide their holders with a work experience that would enhance their ability to locate and hold jobs in the regular labor market -- public or private -- ones which will enable them to move their families off of income assistance and out of poverty.
- . They should not be used by public agencies simply as a means of refinancing their payrolls.
- . There should be provision for part-time employment in these jobs, particularly since many availables might be able to locate part-time employment in the regular labor market which they would like to supplement.

These jobs would pay a low hourly wage rate. One possibility is that we establish a Federally financed floor of 75% of the minimum wage but permit States to supplement up to the Federal minimum wage. This would build in some flexibility to account for regional variations in low skilled labor wage rates. Another possibility would be to key the wage to standards set by the Federal Wage Board. For purposes of illustration (and our cost estimates) we are assuming that this wage rate would be \$1.50/hr -- 75% of the assumed minimum wage of \$2.00 in FY 76, which would yield an annual income of \$3,000 for full-time, full-year work. Availables in training would also receive this wage.

The concept of Federally subsidized public sector jobs is already built into much of the existing manpower legislation, most notably the Emergency Employment Act. By better focusing on availables, our proposal could be accomplished without requiring a massive expansion in such efforts.

One of the major criticisms that is likely to be raised is that under these conditions availables would not have sufficient incentive to look for regular jobs. To avoid this we propose that, unlike the disregard of the first \$1800 of earnings in the regular labor market, none of the earnings of availables in subsidized public sector employment be disregarded, but immediately be subject to the 50% marginal tax rate. Public service employment would thus provide less net income than almost any regular labor market job, even those paying close to half the Federal minimum wage.

#### The Definition of Available

Under the program outlined above, defining an individual as available for work places a burden on both the individual and on the Government. The available's family will have a considerably smaller basic benefit level, and the program must provide many services including, in some instances, a public sector job. We are led to carefully weigh alternative definitions of availability.

- First is a very broad definition of "available" which would include everyone who might conceivably be expected to work. This might include every able-bodied person over 16 years of age, not in school. This broad definition places an extremely high value on the individual having some earnings regardless of the total public funds required to keep the person working (e.g. for child care, other social services, manpower services, public sector employment wages) and regardless of the foregone contribution a parent in the home could have made in household work and child rearing.



- The second is a narrow definition which attempts to weigh the net social (economic) costs and benefits of defining any individual as available for work.

In fact it is probably most desirable to try to strike a reasonable balance between these two approaches. We would like to subject all those adults to the work requirement who we think should be working but our notion of "should" has to be tempered by the public and private costs relative to the likely benefits.

There can be no doubt that one parent in any two parent family should be so defined, as should children over 16 and not in school, and the adult in single parent families where there is no need for child care -- i.e. no children aged 14 or less.

We use fourteen (14) throughout this paper as the age below which it becomes unclear whether some formal arrangements for after school care are needed in the absence of any parents. Certainly a ten year-old requires after school care, but at what age between eleven and fourteen this requirement ceases to be prudent public policy is uncertain.

It is when we begin to examine the implications of defining as available the heads of single parent families with child care needs that it becomes difficult to arrive at a judgment. (Since over 95% of these heads are females we will talk about them as female-headed families.) The costs of preparing these people for, and maintaining them in employment begin to rise steeply relative to expected benefits as we move down the scale by age of youngest child.

The various cost components here that can be directly measured are:

- Youth or child care direct costs (after school and full-time summer).
- Other social services.
- Manpower services including training.
- Subsidized public sector wages and overhead.

Because well over half of these mothers have no high school education, and little or no previous attachment to the labor force, we could expect the costs incurred for them to be substantial. And of course, accompanying these services provided by the Federal government would have to be a large bureaucracy to administer the programs.

We estimate that the additional costs for these services of an H.R. 1 definition of availability -- excluding only mothers with children under 6 -- as opposed to one that excludes any mothers who need child care (child under age 14), would be about \$3 billion in FY 76. At least two-thirds of this would be accounted for by families where the youngest child is 6-10, because most of the families are in this group and they contain, on the average, more children.

In addition to these measurable costs there are two intangible ones:

- The foregone contribution of the mother to household work and child rearing - Even though she is not paid a wage for these services they are of definite value to her family and society.
- The size of the subsidized public sector jobs pool - Defining as available all mothers whose youngest child is 6-14 would result in considerably more demand for subsidized public sector jobs. We estimate that the H.R. 1 definition might as much as double the need for such jobs in FY 76, from perhaps 450,000 to 900,000. This would put a severe strain upon our ability to create the type of jobs we would desire.

While it is impossible to measure these two costs in dollar terms, they are likely to be quite important.

The measurable costs of defining as "available" a mother with a child under 14 could work out to be as much as \$5,000/mother on the average for the Federal government. However, this average figure is misleading because it is precisely those least productive avail-ables that would have to rely more heavily on the subsidized public sector jobs for which the net costs (including child care and other social services) range well above that figure. These costs plus the two intangible ones listed above are to be compared to the value of additional work that would be done by these mothers. It is unlikely that the value of the work accomplished by these "avail-ables" would justify such costs on economic grounds.

Of course, even if we were not to subject them to a work requirement, many of these mothers would choose to work in the regular labor market. Somewhat over a third of all AFDC mothers worked over half time in 1970. This figure could be expected to increase under our proposal because of the stronger incentive structure and employer subsidies. However, in these instances the Federal government would not have to bear the costs of child care and other services if we did not include them under the work requirement.

For these reasons the priorities for people covered by the work requirement should be first, those with older children not in school and adults with no child care needs; second, mothers whose youngest child is near the upper end of the child care age bracket, and last, down to mothers whose youngest child is 6. Our proposal would not subject mothers with day care needs to the work requirement at the outset of the program. After (say) two years we could consider phasing in mothers with younger children. This could depend upon whether:

- our experience with the subsidized public sector jobs and other manpower services indicated that we could successfully increase the number of people with whom we would have to deal;
- general public opinion, after the new welfare system had a chance "to prove itself," strongly favored such an extension of the work requirement; and
- the budget situation would permit the additional outlays required.

#### Unrelated Individuals and Childless Couples

We are not proposing that this approach be extended at this time to unrelated individuals and childless couples. However, a basic Federal income assistance program for this population should be a high priority after a system has been in place for families for a few years. The logic of our approach for families is easily extended to unrelated individuals and childless couples. Except for reasons of incapacitation (much of which would be covered by social insurance), all childless couples and unrelated individuals would be defined as available; thus there would be no need for welfare grants, only manpower and social services and additional subsidized public sector jobs.

#### Federal-State Fiscal Relationships

To decide on the Federal State cost-sharing arrangement for the family program it is helpful to recall these basic ideas:

- . There is a strong Federal interest in establishing a basic minimum system nation-wide;
- . but variations in wage levels, and a desire for generous welfare systems, exist from State to State;
- . and the establishment of the new arrangement should not, itself, financially penalize a State.

We propose to balance these considerations by the following provisions:

- . In addition to the basic floor of a \$2700 benefit, the Federal government would provide for a special floor of \$2200 for a family of four when the program starts in FY 76. We could expect that only a few States might be below this benefit level by that time when the value of cashed-out food stamps is added to the State payment levels.
- . Since this special Federal floor is too low for most States, we would offer to provide 100% financing for benefit levels up to \$2700 which would be called the basic Federal floor.
- . The Federal minimum subsidized public sector job wage rate would apply to all States.
- . States could supplement both the basic grants and the subsidized public sector job wage rate at their own expense provided that they do not interfere with the program structure. Because the program structure varies considerably from present law this would limit the State's ability to maintain payment levels for all present recipients.
- . We would provide hold harmless payments to high paying States for changes in the caseload caused by new eligibles.

#### Deserting Parents and Fraud

The problems of deserting parents and fraud are very serious in the current program. The public perception of the program's integrity which results from these problems is an even more damaging outcome than the excess monetary cost which results. Any new welfare program must explicitly deal with these issues.

In the case of deserting parents the basic approach should be preventive. That is, the program itself should not provide incentives for the father to leave the family. Since the proposed program includes the working poor and there are significant disregards of earned income, there should no longer be strong incentives for family break-up which result from program design. But we should also recognize that the increases in family break-up which are occurring in our society are prevalent at all income levels, so there are obviously other factors involved. This means that despite our program's design we must anticipate that desertions will occur.

Desertions generally mean that support payments will be denied the family and, therefore, the welfare check will be larger than necessary. The proposal here (similar to that contained in H.R. 1) is that any parent who has deserted his family shall owe the United States the amount paid to the family during his absence. To enforce this proposal we would establish central and local units to locate the deserted parents and arrange for the appropriate payments.

Decreasing to acceptable levels the amount of fraud which exists is an even more difficult task. The following steps will be taken to reduce the level of fraud:

- The initial eligibility determination will make maximum use of the evidentiary method which requires that applicants provide documentary proof of critical eligibility variables such as age and marriage. Social security numbers will be required of all family members to prevent duplicate filing and allow for cross-checks on income, particularly earnings.

- A quality control unit will make periodic sample checks to determine the level of fraudulent activities by eligibility factor and geographical region.
- Special investigative staffs will be developed to prosecute suspected fraud cases.

#### Costs

Below we present estimates of the costs of the proposed programs alongside the costs of present law and the House version of H.R.1 for FY 76, the presumed effective date. In this ~~cost~~ presentation we include effects on existing programs which would be affected by enactment of our proposal. In general, we see the program consolidating that portion of the existing manpower and employment programs that benefit the low income population.

Specifically we propose the following modifications in current programs:

- Cash-out the Cuban Refugees program.
- Focus up to one-half of the expenditures under the EEA public service employment program and the programs of the manpower Development and Training Act (MDTA) and the Economic Opportunity Act (EOA) on the welfare population.
- Eliminate the WIN program

In the table below we show the costs of the proposal on the assumption that no single-parent-family heads with children requiring day care are classified available for work. Another important assumption is that all States will participate at the \$2700 level; this assumption was made only to simplify the cost calculation. Below the table we present some "add-ons" which would result from changing the assumptions in the basic table.

COST COMPARISONS OF FAMILIES PROGRAMS  
FY 76 (\$ billions)

|                                             | <u>Current Law</u>           | <u>HR 1</u> | <u>Proposed</u> |
|---------------------------------------------|------------------------------|-------------|-----------------|
| Payments to Families (includes admin.)      | \$ 6.1                       | \$ 6.5      | \$ 6.9          |
| EEA, MDTA, EOA                              | 2.6                          | 2.6         | 1.3             |
| Subsidized Public Sector Jobs <sup>1/</sup> | 0                            | .8          | 1.8             |
| WIN                                         | .7                           | 0           | 0               |
| Child Care                                  | { Included<br>Under<br>WIN } | .8          | 0               |
| Services, Training                          |                              | .6          | .3              |
| Residual Food Stamps                        | 2.5                          | .4          | .4              |
| Employer Subsidies                          | (Under WIN)                  | 0           | 0.2             |
| Hold Harmless                               | 0                            | 1.4         | 1.4             |
|                                             | <u>11.9</u>                  | <u>13.1</u> | <u>12.3</u>     |

"Add-ons" to cost of Proposed Program (\$billions) <sup>2/</sup>

- |    |                                                                                             |        |
|----|---------------------------------------------------------------------------------------------|--------|
| a) | For classifying as available those single parent family heads whose youngest child is 11-14 | \$ 1.0 |
| b) | For classifying as available those single parent family heads whose youngest child is 6-14  | \$ 3.0 |

<sup>1/</sup> Includes \$3000 in wages and \$1000 in general overhead for 450,000 availables.

<sup>2/</sup> Net additional costs incurred by defining a female head of family as available include \$500 for services, \$1000/child for child care, and, for each full-time subsidized public sector job, \$1,000 in overhead and \$1,500 - \$2,500 in wages (net of reduction in family benefit levels). We estimate that 150,000 jobs would be required under "a" and 450,000 under "b."



### CONCLUSION

To summarize, it is useful to point out the strengths of our approach over that of H.R. 1 and the Senate Finance Committee.

Our proposal, in contrast to H. R. 1, would not:

- . cost as much;
- . pay families benefits that take into account any members who society believes should be available for work;
- . necessitate the determination of what is an "acceptable" job in the regular labor market, require regulation and enforcement concerning some minimum number of hours of work in the regular labor market in order to satisfy the work requirement, or make receipt of benefits conditional upon working in a job he or she would not otherwise want to take; or
- . cause disruption of the low-wage States where the Federal basic benefit levels might be significantly above what the States would otherwise want to have.

On the other hand, our proposal, in contrast to H. R. 1 would:

- . result in a system that is more simple and is more "self-administering;"
- . have a more credible set of employment policies and work incentives which hold significant promise of reducing welfare rolls over what they would otherwise be in the long run.

In comparison to the approach of the Senate Finance Committee to welfare reform, our proposal has the following advantages. It would:

- . cost approximately \$5 billion less;
- . put into place a uniform national basic program structure, instead of retaining State AFDC programs;
- . result in a much smaller demand for subsidized public sector jobs; and

treat families with available members in such a way that (1) there is no incentive for fathers (with young children) who do not want to work to desert so that the remaining family members can become eligible for welfare benefits and (2) the other members of an available's family are not penalized and left destitute if he or she refuses to work.

ASSISTANCE TO STATES AND LOCALITIES: SPECIAL REVENUE  
SHARING IN HEALTH EDUCATION AND SOCIAL SERVICES

I. Introduction

In FY 1971, aid from the Federal government financed twenty percent of State and local government expenditures. The aid was distributed through 530 categorical programs whose administrative regulations, eligibility requirements and sheer number served to overwhelm public officials at all levels.

Many of the programs are a legacy of the past decade. The 1960's were a period of rapid Federal expansion in a number of areas: education, health, services for the poor, and environmental protection are examples. In almost every case the motivation was commendable: devise a Federal solution to a recognized national need.

But the Federal government, like any organization, is limited in its capacities. As it grows, its internal coordination deteriorates and it loses its capacity for focused action. This problem now exists in Health, Education and Welfare and it has brought us to the program reassessment we are now making.

Our reassessment recognizes that HEW can manage well only a limited number of programs. The programs we retain at the Federal level must be carefully selected. The remainder of our programs should be given to the States and localities in a form which they will find most useful. We undertake this reassessment not out of mean-spiritedness nor out of a desire to shirk our responsibilities. Rather, we reassess our programs because we now know that to attempt too much is to accomplish nothing at all.

Three principal outcomes of our program reassessment are the Special Revenue Sharing packages in Health, Elementary and Secondary Education, and Social Services described in this paper. The packages have been designed with three goals in mind:

- To simplify program administration and decentralize program decision making
- To give Congress, the Administration and the public a clearer picture of total program costs
- To vindicate important Federal interests through a minimum set of enforceable program strings.

Each Special Revenue Sharing package has been built largely around State formula grant programs (Some project grant programs are also included). As presently constructed, these grants are automatically allocated to States and localities through legislatively determined formulae. The programs which they finance are run by the States and localities. The categorical boundaries which separate one program from another often serve to increase administrative structure without increasing human benefits.

Vocational education is a case in point. The Vocational Education Act of 1963 provides for a general State grant for vocational education programs, another State grant for research and training in vocational education, another State grant to finance exemplary programs and projects in vocational education, another State grant for cooperative vocational education programs, another State grant for work-study programs for vocational education students, and two additional State grant programs. The issue here is a simple one: does the Federal government know how its vocational education funds should be divided among these alternative uses in every State? We believe it does not. Student needs, labor force needs, and a host of other factors vary too widely from State to State to be adequately described in any set of formulae. The alternative is to give each State a single vocational education allotment and let State and local officials tailor their programs to their needs. This is the alternative we have chosen.

Each Special Revenue Sharing packages was designed in several stages. First, existing categorical programs were consolidated into broad program areas: vocational rehabilitation services, education for the disadvantaged, services for the aging, and so on. We next examined the program areas themselves to see where further consolidation was possible. In some cases, whole areas were combined. In other cases, we achieved limited consolidation through the authority to partially transfer funds from one area to another. Throughout, our decision rule was to abandon program restrictions which did not vindicate an important Federal interest.

As a result of this process, each Special Revenue Sharing package substantially clarifies Federal-State fiscal relations. Program distinctions which currently exist only on paper are abandoned. Greater decision making power is placed in the hands of the States and localities. Many small programs are consolidated into large, broad purposed grants. This financial consolidation will give both the government and the public a better idea of the magnitude of the Federal effort in major areas. It will also provide a more logical basis for future policy debates.

Special Revenue Sharing is not General Revenue Sharing. Each Special Revenue Sharing package maintains controls over State expenditures to assure the promotion of important Federal interests. In some cases, States are required to spend at least a fixed percentage of funds on certain groups--the handicapped in Education and the poor in Social Services are two examples. These targeting requirements have been introduced where we have evidence that States and localities want to reallocate funds away from politically vulnerable groups. In the Education package, management restrictions, including comparability, govern the design of compensatory education programs for the disadvantaged. These restrictions are compatible with the philosophy of Federal retention of control in certain key areas.

All three Special Revenue Sharing packages have other general restrictions: a planning process which is open to both local officials and concerned citizens; a requirement that books and other relevant records (e.g., school test scores) be maintained and be open at all times to the public and Federal monitors. Each package also contains non-discrimination provisions and a set of procedural sanctions for non-compliance with program regulations.

Even with these restrictions it has been possible to substantially reduce the web of regulations and rules with which State and local officials have to deal. As their administrative burden decreases, they will be able to devote more time to what should be their primary responsibility: the design and delivery of services to their constituents.

## II. Health Special Revenue Sharing

### A. Introduction and Purpose

The Health Special Revenue Sharing proposal is designed to assist States in establishing a broadened public health function aimed at controlling the causes of disease and poor health. The proposal will support traditional public health activities including the protection, prevention, and control of communicable and chronic diseases, the control of alcoholism and drug abuse, public health education, mental health, and community environmental health activities, includes support for States to provide medical social services: counseling, outreach, transportation and other services which will not be covered by national health insurance.

### B. Program Authorities to be Consolidated

Current programs that will be folded into Health Special Revenue Sharing are shown in Table I. The proposal will include Departmental programs which are currently funded through both formula and project grants. These grant programs will be consolidated into a single

TABLE I

Current Programs to be Folded into Health Special Revenue Sharing

| <u>Formula Grants</u>                   | <u>FY 74 HEW Budget<br/>Estimates<br/>(in millions)</u> |
|-----------------------------------------|---------------------------------------------------------|
| 314(d)                                  | 90                                                      |
| Alcoholism                              | 30                                                      |
| Narcotics Addiction                     | 15                                                      |
| <u>Project Grants</u>                   |                                                         |
| Drug Abuse                              | 114 <sup>1/</sup>                                       |
| Alcoholism                              | 40 <sup>2/</sup>                                        |
| V.D.                                    | 33                                                      |
| Lead poisoning, rodent control, etc.    | 22                                                      |
| Communicable Diseases (other than V.D.) | 9.5                                                     |
| <u>Medical Social Services</u>          | <u>150</u>                                              |
| TOTAL . . . . .                         | 523.5                                                   |

<sup>1/</sup> An additional \$25.2 (million) for Drug Abuse is shown under Market Services Development

<sup>2/</sup> An additional \$16.2 (million) for Alcoholism is shown under Market Services Development.



block grant. No matching requirements will be made on the States for receiving Health Special Revenue Sharing funds.

Health Special Revenue Sharing is built around the current 314(d) State grant, formally titled Grants for Comprehensive Public Health Services. To this have been added formula and project grants for V.D. control, lead poisoning, rodent control, other communicable diseases, and an additional sum to cover the costs of medical social services. Each of the existing programs in the package is currently funded and administered primarily through State and local health departments.

Present Departmental programs included in Health Special Revenue Sharing are currently funded and administered mainly through State and local health departments. Some would argue that without strict Federal earmarks for certain activities, the States may no longer continue to fund them at a level desired by the Federal Government. But in public activity, Federal and State governments have substantially similar goals. This can be demonstrated by examining the 314(d) program. In 1967, Section 314(d) of the Public Health Service Act consolidated nine public health categorical programs into a single block grant to the States. Since that time, the shift in State public health activities has been minimal; removing Federal categorical restrictions did not result in major changes in State public health activities. States not only have continued to fund these activities, but most States now spend far more in support of these activities than the amount they receive from the Federal government. In 1971, Federal public health expenditures under the 314(d) program totaled \$90 million; total State expenditures that year for these same programs were more than \$400 million.

#### C. The Population Served

The programs listed in Table I currently serve a wide group of people. There is little reason to believe that the composition of this group will change under Health Special Revenue Sharing. Public health problems, including areas like drug abuse, have large externalities. A communicable disease among one group quickly may spread to other groups. Because of these externalities, States will continue to have an incentive to provide services to all who need them. Accordingly, the problems of Federal antidiscrimination enforcement are reduced.

#### D. The Distribution Formula

The Health SRS package will be administered as a single block grant. It will be distributed among the States on a formula based on population, per capita income and medical need including the incidence of alcoholism, V.D. and drug abuse.

#### E. The Administrative Structure

Health SRS funds will be allocated to the Governor, who will be required to establish a planning process for determining the distribution of the funds within the State. The Governor will not be required to designate the State public health agency to administer the funds. Instead, he may select the administrative structure of his choice. Thus, several State agencies may be involved in administering the program. Nor will there be a requirement to designate a particular agency to administer Health Revenue Sharing funds at the local level. There is no such requirement at present on any program to be consolidated into Health Special Revenue Sharing, and there appears to be no adequate reason to add such a requirement.

#### F. Additional Requirements and Enforcement Procedures

Wherever possible, requirements in existing programs have been eliminated as these programs have been folded into the Health SRS package. At present, the 314(d) State grant contains a 15% earmark for mental health. Because SRS is supposed to increase State authority and discretion, this earmark has been eliminated. This elimination will result in some political opposition, but there is no programmatic justification for its retention. History shows that States have always supported mental health activities. Under Health SRS, they are free to continue these activities if they consider them to be priorities.

A further earmark on the 314(d) grant requires that no more than 30% of the funds may be retained for expenditure at the State level; the remaining 70% must be "passed through" to local governments. This earmark also has been removed from the Health Special Revenue Sharing proposal; State and local political conditions will determine the amount of services provided by State employees and the amount provided by local personnel.

Certain minimum procedures are necessary for all Special Revenue Sharing packages. Funds cannot be used for programs which discriminate on the basis of race, religion, creed, national origin, or sex in either program management or services delivery. This regulation applies both to the State and to any agencies with whom the State contracts.

States will be required to maintain expenditure records of Health Special Revenue Sharing which are open to the public and which are made available to the Secretary at the end of each fiscal year. This requirement is not present in the 314(d) grant, resulting in strongly expressed dissatisfaction from Congress.

This open records condition forms the basis for enforcement in all SRS packages. Without it, there is little practical distinction between Special Revenue Sharing and general fiscal relief. The

absence of an open records requirement in the 314(d) grant program resulted in strong Congressional dissatisfaction on these grounds.

If the Secretary finds that funds are not being spent in accordance with the conditions of the Act, he will have the following enforcement procedures available:

#### Enforcement Procedures

- (1) He can terminate all payments to the States until the State demonstrates it is prepared to come into compliance.
- (2) He can terminate all payments to activities affected by the non-compliance until the State demonstrates it is prepared to come into compliance.
- (3) He can operate directly or through arrangements with other activities which are found to be in non-compliance until such time as the State demonstrates that it is prepared to come into compliance or indicates that it no longer wishes the activities to be continued.
- (4) He is authorized to recover such Federal funds as have been spent on activities affected by the non-compliance during the period of non-compliance.
- (5) In addition, the Secretary will be authorized under this act to bring proceedings in Federal district court against appropriate individuals to compel compliance with the requirements of the Act. The Act will also authorize civil suits in Federal district court by individuals who believe they are aggrieved by failure of a State to comply with one or more of the Act's requirements.
- (6) Finally, the Act will direct the Secretary to establish and publicize the existence of an office within the Department Of HEW to receive and investigate citizen complaints.

### III. Education Special Revenue Sharing

#### A. Introduction and Purpose

Historically, the Federal government's role in Elementary and Secondary education has been one of limited interventions, in particular the provision of aid to selected target populations. Our Education Special Revenue Sharing package seeks to maintain that role while increasing administrative flexibility at the State and LEA levels. The heart of our proposal is our Educational Special Revenue Sharing package of 1971, which provided a substantial consolidation of education categorical programs. Our current proposal builds upon this original package through an inclusion of additional programs

and through a restructuring of the 1971 package earmarks.

#### B. Program Authorities to be Consolidated

Our 1971 Education SRS package had five area earmarks: programs for the disadvantaged, programs for the handicapped, vocational education programs, SAFA Federal Impact Aid, and Supportive Services. Our revised package retains each of these earmarks with substantial modifications. These modifications are shown in Table II.

The disadvantaged earmark has been expanded to conform with the design and funding of our EEOA proposal. When fully funded the earmark will include \$2,597 m. \$1,742 m. will come from the current ESEA Title I. \$789 m. will come from ESA when that program expires in FY 1974. Together this funding will be sufficient to provide \$300 per child for every school age child defined as poor under the Orshansky-Social Security poverty index. The funding will also allow some extra resources for schools with high concentrations of disadvantaged. The earmark also includes \$66 m. of Vocational Education Act funds, the current 15% set aside for vocational education of the disadvantaged. This relocation of the VEA funds in the disadvantaged earmark will help States in developing a comprehensive approach to the education of disadvantaged students.

The issue of comprehensive strategies for target groups also arises in the earmark for the handicapped. We have revised this earmark upward to \$82 m. \$38 m. of this amount represents the consolidation of handicapped programs in our 1971 Education SRS package. \$44 m represents the current 10% set aside of Vocational Education Act funds for vocational education of the handicapped. Again, the combination of the two funding sources should aid States in the development of a more unified approach to handicapped education.

The new Occupational Education earmark replaces the Vocational Education earmark of our 1971 package. It represents a merger of our current formula grant programs in the occupational training area. The funding level of \$389 m. represents \$17 m. from the current Occupational Education program and \$332 m. from VEA, the portion of VEA funds which are now aimed at the general population (as opposed to the handicapped and the disadvantaged). This earmark is designed to encourage the funding of both existing occupational training programs and the funding of new programs including the adoption of models developed under our Career Education program.

A SAFA A earmark represents a change from our 1971 SRS package and a return to the budget proposals of 1969-70. Communities who lose property tax dollars from children who live on Federal property have a legitimate grievance. These communities are aided under the SAFA A portion of Impact Aid, aid to children whose families live on Federal property. The same grievance does not properly extend to SAFA B children; children whose parents work but do not live on Federal property. Often this SAFA B aid goes to the "wrong" district, a rich bedroom community whose residents work on Federal property in a neighboring city.

TABLE I

Elementary and Secondary Education Special Revenue Sharing Package

| 1971 Package Earmarks                                                                                                                 | FY 74 HEW Budget<br>Estimated (millions) | Revised Proposal<br>Earmarks                                                                            | Estimated FY 74<br>Funding (millions) |
|---------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|---------------------------------------------------------------------------------------------------------|---------------------------------------|
| Title I                                                                                                                               | \$1,742                                  | Disadvantaged (EEOA)<br>(includes current 66 million<br>set aside in Voc. Ed. for<br>the disadvantaged) | \$2,597                               |
| Handicapped                                                                                                                           | 38                                       |                                                                                                         |                                       |
| SAFA (A + B)                                                                                                                          | 374                                      |                                                                                                         |                                       |
| Vocational Education<br>(includes 442 million Voc.<br>Ed. State grant program and<br>38 million Voc. Research<br>State grant program) | 480                                      | Handicapped<br>(includes current 44 million<br>set aside in Voc. Ed. for<br>the handicapped)            | 82                                    |
| Supportive Services 1/                                                                                                                | 284                                      | SAFA A                                                                                                  | 265                                   |
| TOTAL                                                                                                                                 | \$2,918                                  | Occupational Education                                                                                  | 427                                   |
| Proposed Transfers into<br>Revised Package                                                                                            |                                          | Revised Supportive Services 3/<br>(includes Hold Harmless)                                              | 488                                   |
| ESA (upon its expiration<br>in FY 74)                                                                                                 | 789                                      | GRAND TOTAL                                                                                             | \$3,859                               |
| Occupational Education                                                                                                                | 57                                       |                                                                                                         |                                       |
| Hold Harmless 2/                                                                                                                      | 42                                       |                                                                                                         |                                       |
| Adult Education                                                                                                                       | 53                                       |                                                                                                         |                                       |
| GRAND TOTAL (Adm. Package<br>plus transfers)                                                                                          | \$3,859                                  |                                                                                                         |                                       |

- 1/ Includes ESEA Titles II, III and V  
2/ The Hold Harmless funds are distributed according to a separate formula to insure no State receives less under SRS than it now receives.  
3/ Calculated as a residual so that the dollar value of the revised package equals the dollar package of the programs it replaces. The package includes Hold Harmless funds.

We propose that SAFA A aid be retained and earmarked while SAFA B aid be eliminated and its funds be transferred to the General Supportive Services earmark.

The Supportive Services earmark has been revised to act as a kind of hold harmless provision. In our original Education SRS package, the \$284 m. Supportive Services earmark represented a major advance: the combination of categorical programs for library support, school support and so on, into one funding earmark. Our current proposal retains this consolidation and adds to it the \$53 m. formula grant program in Adult Education, the \$16 m. now going to SAFA B children and a \$42 million hold harmless. By constructing the earmark in this way and providing an appropriate list of fundable activities, we permit every State to continue existing programs (including adult education and SAFA B), if it so chooses.

The Handicapped, Occupational Education and Revised Supportive Services Earmarks all include discretionary transfer authority. Each State is permitted to transfer up to 30% of the funds attributable to any one of these areas to any other area. Transfers out of the Disadvantaged and SAFA A earmarks are not allowed.

#### C. The Population Served

Our revised Education SRS package concentrates resources on three target groups: the disadvantaged, the handicapped, and users of occupational education services. In addition, the package provides Impact Aid to districts with children housed on Federal land and some general population support through Revised Supportive Services. These target groups provide a realistic description of our current role in Elementary and Secondary Education.

#### D. The Distribution Formula

A State's share of Education SRS funds will be based on the sum of three terms:

- (a) Disadvantaged aid will be computed according to the number of school age children in the State who fall below the Orshansky-Social Security poverty index. Additional funds will go to those districts with a substantial concentration (e.g. above 30%) of disadvantaged students.
- (b) SAFA A Impact Aid funds will be computed on the basis of the number of children in a State whose parents live on Federal property.
- (c) Handicapped and General Supportive Services allocations will be based on the number of school age children in the State, modified by State per capita income.

Aid for disadvantaged children and SAFA A children will pass directly through to the districts with those children. Responsibility for the allocation of Handicapped and Supportive Services funds will remain with the States.



#### E. The Administrative Structure

The State legislature in each State will designate an administrator for the Education SRS package. We expect this administrator to be either the Governor or the State Superintendent of Education, but we leave this choice to the State's political process.

#### F. Additional Requirements and Enforcement Procedures

Unlike public health programs, education is an area where States have strong incentives to disobey Federal regulations. Our recent audits of Title I funds suggest that where possible, States and LEA's will use these funds to substitute for rather than supplement existing local programs. For these reasons, the kinds of strings we place on the Education SRS package are particularly important.

All programs will be subject to the Equal Educational Opportunity Act language of Title II (a-f). This language prohibits discrimination on the basis of race, color or national origin, and any transfer or student assignment patterns which serve to increase the existing degree of segregation within the school system. Discrimination based on sex or creed will also be forbidden.

All programs will be required to maintain open books of expenses and other information essential to the public evaluation of the program including, where applicable, test scores by school.

The disadvantaged earmark will contain a number of additional regulations strings. All districts providing compensatory services will have to maintain comparability of program though the current five ratios on which comparability is judged (student/teacher, student/para-professional, etc.) can be reduced to two ratios: student/personnel, and dollars/students.

Each program will be required to maintain a Parent Advisory Council as is now required in Title I. To facilitate the operation of these councils, they should be allocated a small portion of the program's administrative expenses.

As in EEOA, at least 3/4 of the disadvantaged funds will be required to be spent on the teaching of basic skills including reading and math. Finally, each program will be required to carry out a pre and post program testing evaluation. These strings are consistent with our philosophy of improving the management in those areas where a Federal role is justified.

The enforcement procedures for Education SRS regulations will be similar to those described for the Health SRS package: the partial or total termination of payments, the recovery of payments spent in programs not in compliance with Federal regulations, the initiation



of citizen suits against appropriate education officials, the authority of the Secretary to bring suit in district court to require compliance with Federal regulations, and the authority of the Secretary to directly or by contract carry out an activity where that activity was out of compliance with Federal regulations. These provisions should offer adequate protection against abuse.

#### IV. Social Services Special Revenue Sharing

##### A. Introduction and Purpose

The Social Services Revenue Sharing package is designed to aid States and localities to provide more effectively protective services for particularly vulnerable citizens, and services which enhance independence and self-sufficiency. These services include:

- Social services for the poor not covered under workfare
- Rehabilitation services
- Day care, child development, and child welfare services
- Youth development and delinquency prevention
- Services to the Aging

Social services deal directly with the interaction between individuals and their social environment. For this reason, the outcome of social service efforts is particularly sensitive to local, cultural, and even individual variation. Thus it is especially appropriate that program decisions in this area devolve to State and local officials, who can respond more adequately to locally varying needs.

##### B. Program Authorities to be Consolidated

The Social Services Special Revenue Sharing package consists of a single, consolidated block grant. Included in the package are funds now being expended under Child Welfare, the non-experimental portion of Head Start, Vocational Rehabilitation, the social services titles of the Social Security Act, and the formula grant portions of Developmental Disabilities and the Older Americans Act. These funds are listed in Table III. The construction of the package requires several points of explanation.

##### Head Start

Inclusion of the bulk of Head Start funds in the revenue sharing bill implies a major change in the administrative structure of the program. Head Start funds are currently allocated among States on a formula basis, but the program is officially considered an experimental Federal project grant program. The SRS package transfers the majority of Head Start funds (\$365 m.) to the States while \$60 million would be retained at the Federal level for research and capacity building in child development.

TABLE IIICurrent Programs to be Included in Social Services Revenue Sharing

|                                                   |                 |
|---------------------------------------------------|-----------------|
| Social Services (Titles I,<br>IVA, X, XVI of SSA) | \$2,000 million |
| Child Welfare                                     | 46              |
| Head Start                                        | 365             |
| Vocational Rehabilitation                         | 645             |
| Developmental Disabilities                        | 22              |
| Services to the Aging                             | <u>42</u>       |
|                                                   | \$3,120 million |

The decision to include Head Start in revenue sharing is based upon two considerations:

- At \$400 million it is too large to be seriously experimental; it is a service program. Yet the "experimental" label has been the rationale for not expanding the program beyond its current coverage of 15% of eligible children. The proposed change brings policy into line with reality.
- The consolidation of Head Start with day care under Social Services facilitates the development of a single delivery system for all child development programs. This position was taken last year in the Administration specifications for the child development bill.

Revenue sharing Head Start is, however, likely to mean reduced involvement of the Community Action Agencies who currently administer over 90% of Head Start grants. In addition, there may be severe transitional problems as States and localities eliminate Head Start projects which are regarded as politically troublesome. To ease the transition of this program, we suggest that the inclusion of Head Start in the Revenue Sharing package be delayed for one year after the enactment of the bill. This would allow time for both CAP agencies and Head Start programs to generate other resources.

#### YDDPA, DD, and AOA

Under the Social Service SRS package, States are given the option of providing services to youth, the aged, and the developmentally disabled. However, only the formula grant portions of DD and AOA are folded into the package.

The project grant programs under YDDPA, Developmental Disabilities, and AOA are included in the capacity building package to ensure their continued use for innovative market development activities. We propose the nutrition portion of AOA be converted to income assistance to aged individuals. A combination of enhanced purchasing power and stimulation of private suppliers will be more effective in meeting the nutritional and social needs of the aged than the program as it now stands.

#### Vocational Rehabilitation

Under our proposal, vocational rehabilitation services would be for the first time consolidated with social service authorities for the poor, and would be required to emphasize services for the handicapped poor. This position is consistent with Administration proposals in the last Congress that a fee schedule be mandated for services under the VR act. As it now stands, the VR program authorizes

the use of funds for a wide range of services, many of which constitute an overlap with other social and medical service authorities. This consolidation facilitates elimination of the inefficiencies caused by such overlap. It should be noted that increased targeting on the poor, implicit in this proposal, would not be more expensive: it is estimated that 100% coverage of the handicapped poor would presently cost \$450 million--\$200 million less than the current program which covers all handicapped persons. Targeting services to the poor would not result in justification for inflating the rehabilitation budget.

At the present time, \$350 m. of Vocational Rehabilitation funds provide services which will be covered under National Health Insurance when that program goes into effect. We recommend that the VR program savings, generated by health insurance, be allowed to remain with the States and localities.

#### C. The Population Served

Approximately 90% of the funds in Table III are currently being spent on the poor. (Social Services, Head Start, and approximately 60% of Vocational Rehabilitation) To insure that this targeting is maintained, we propose a requirement that 90% of the service funds in each State be targeted on the poor. A fee would be assessed, where appropriate, for services to the non-poor.

To assure continued service to those target groups currently specified under the categorical programs to be consolidated, we propose that a fixed percentage of expenditures be allotted to each of the following categories: the aged, the disabled, and children and their families. The proportion of funds allocated to each category would follow current expenditure patterns. For the first year (before the inclusion of Head Start) the following earmarks are suggested for each category:

##### First Year

|                       |      |                  |
|-----------------------|------|------------------|
| Children and Families | 60%  | (\$1.65 billion) |
| Disabled              | 30   | (\$ .83 )        |
| Aged                  | 10   | (\$ .28 )        |
| Total                 | 100% | (\$2.76 billion) |

After Head Start is included in the package a shift toward children's services would be necessary:

##### Subsequent Years

|                       |      |                  |
|-----------------------|------|------------------|
| Children and Families | 64%  | (\$2.01 billion) |
| Disabled              | 27%  | (\$ .83 )        |
| Aged                  | 9    | (\$ .28 )        |
|                       | 100% | (\$3.12 billion) |

The Aged, Disabled, and Children and Families Earmarks all include discretionary transfer authority. Each State is permitted to transfer up to 30% of the funds attributable to anyone of these areas to any other area, to respond to varying State and local conditions.

#### D. Formula for the Distribution of Funds

We recommend the Social Service revenue sharing funds be distributed using a single allocation formula based upon the number of low income individuals in each State as defined by the Orshansky-Social Security index. Slight weighting in one or another client group (the aged, children, handicapped, urban populations) could be incorporated if necessary for political appeal, but it is unlikely that the resultant allocation would significantly differ from one based on income alone.

#### E. Administrative Structure

The nature of Social Services does not provide automatic incentives for States to offer an equitable program. The area contains a history of municipal interest, State disinterest and city-State conflict all of which suggest the need for a carefully drawn administrative structure.

The question of program administration centers on two issues:

- How are funds distributed among local areas?
- Who is the program agent in each local area?

We propose that the Social Service SRS package require each State to distribute funds among local areas in proportion to their poverty populations. Specifically, 90% of the State's funds should be allocated in this fashion while 10% of the funds should be reserved for the Governor to allocate at his discretion.

Program agents and program content should be chosen through an open planning process guided by the State. This process must include the Governor or his agents, State and local officials, potential program clients and citizen representation. The resulting program and choice would be published in newspapers in the State.

#### F. Additional Requirements and Enforcement Procedures

In the previous sections, we have outlined three program requirements: a 90% targeting of funds on the poor, a fee schedule, where appropriate, for services for the non-poor, and an intra-State formula for the distribution of funds. To this list we add the additional requirement that States maintain their current level of effort in social services.

A maintenance of effort provision is required because the SRS package is designed to promote program simplification but not fiscal relief. Without such a provision, evidence suggests that States may well withdraw their current matching share of social services monies.

Other administrative requirements to focus funds on particular services or groups of recipients, could be added if necessary. The process of enforcement in Social Services SRS will resemble the enforcement process in the other SRS package. In the Social Services, anti-discrimination regulations will be supplemented with an additional condition that all programs must be voluntary on the part of the recipient.

#### V. Conclusion

The Special Revenue Sharing packages in Health, Education and Social Services contain a total of \$7.5 billion, one quarter of all Federal grants-in-aid to State and local governments. Together they consolidate 42 State formula grants and six project grants into eight broad categories: one in Health, five in Education and one in Social Services. The consolidation will permit State and local officials to reallocate their time to where it is needed most, the design and implementation of programs to serve their constituents.

## CAPACITY BUILDING

## I. INTRODUCTION

The decision to devolve a greater amount of Federal resources and allocation authority to individuals and State and local governments necessitates that we assure that people can obtain the goods and services they need, and that State and local governments have the capacity to utilize effectively the additional resources provided to them. Thus a complement to decentralized decision-making authority is the need for the Federal government to focus its activities to improve the capacity of State and local governments and other institutions to provide needed human services. Accordingly, we propose that the primary Federal role for DHEW over the next several years be as an innovator, experimenter, demonstrator, developer, and evaluator, not as a service provider.

The Department is to be principally a purveyor of innovation and change. Acceptance of change depends on the structure of particular institutions and on the characteristics of the proposed innovations. Specifically, where governments or other institutions can and would implement a particular good idea, dissemination of research results may be sufficient to produce the desired change. Where they lack the know-how, technical assistance, limited financial assistance through market and services development, or special manpower development programs may be required.

There are, of course, other activities which do not fit neatly into our categories of financial assistance to individuals, special revenue sharing or capacity building. Many of these activities remain in DHEW for historical (Special Institutions) or functional (FDA) reasons. These activities, and our proposed rationalization of their role within the Federal government, are discussed in the final paper at Tab E entitled "Other HEW Activities." A brief summary of how we propose to handle capacity building activities concludes this section of the paper. Each of the subjects summarized is discussed under Tabs D-1, D-2, and D-3.

- Special manpower development is to focus on critical manpower shortages. We propose to use general higher education student assistance (discussed in the higher education paper) as the primary means to allow access to all forms of higher education. Where special circumstances--inadequate student flow, insufficient institutional training capacity, or inappropriate distribution of output--require Federal intervention in critical skill areas, we propose three comprehensive authorities--for health, education and social services--to be used under stringent criteria. Under each of these



authorities student assistance would provide incentives for (1) skill training in shortage occupations, (2) specific professions to work in shortage areas and (3) special access for minorities to certain professions. In addition, we would provide institutional aid in order to (1) maintain enrollment at an appropriate level, (2) encourage special skill training and (3) encourage curriculum and other teaching reforms. Finally, the Secretary would be given authority to regulate licensure requirements. Because of our general student aid proposals and because existing programs are not well targeted to these objectives we propose a significant reduction in funding for specialized manpower programs--down from the current FY 74 \$1.1 billion to approximately \$400 million in FY 78.

- The focus of the market and services development is overcoming market imperfections in the provision of services by, among other things, implementing delivery modes which may have been experimentally demonstrated through research. We propose a general cross-cutting authority for services integration plus four consolidated authorities: elementary and secondary education, higher education, health, and social services. These authorities would combine the many programs now providing technical assistance, manpower retraining, planning, start-up funds and service subsidies. The authorities would be used strictly for time-limited implementation of proven techniques aimed at institutional reform, that would not otherwise be implemented e.g., HMO's. We also propose a general loan guarantee authority for construction which would replace several existing authorities.
- The focus of research and development is to be on discovering new knowledge and disseminating that knowledge. We propose consolidation of the many separate R&D programs into five major research activities/authorities, leaving biomedical research as a sixth major category but with the separate authorities of the various NIH Institutes. We do not propose any major change in current R&D funding levels.

One way to characterize the capacity-building proposals we make is to view them as rationalizing the purposes of programs in this area. Rather than fragmenting the functions of R&D, manpower, market development, and service subsidy by authorizing them separately for each problem, we propose to combine these functions into a few consolidated packages covering a wide range of problems.

A major benefit of this approach lies in the substantial simplification of purposes, and corollary improvement in management, that this will enable. For the first time we will have a capability to direct our capacity-building activities without continuing service subsidies diverting our attention from the real purposes of the programs. Equally important, the consolidation of authorities will allow us to target far better on the problems we can deal with best.

The second major benefit lies in the contribution of our proposals to intergovernmental relations. The three manpower, six market and services development and five R&D authorities we propose will replace innumerable separate programs, each with its own rules and regulations and funding pipeline to state and local governments or private institutions. Small grants can carry as much red tape as larger ones, and grant consolidation need not stop at special revenue sharing. The new programs will be managing hundreds of projects each year--these will still require detailed, separate management. Nonetheless, the net improvement will be substantial.

A third benefit lies in the clarification of respective roles for capacity-building versus financial assistance. The new approach will provide us with reasonable criteria for judging, as new problems and priorities emerge, how to handle their various aspects. If a problem requires substantial additional resources it would normally be appropriate to modify our financial assistance packages. If it requires research, it would be appropriate to modify our research program. And so forth. In many cases, we expect that this will show that the problem does not require new resources, but redirection of existing ones. Budgetary discipline and control should be substantially easier.

Each of these advantages carries some costs, these need not be elaborated. No change is costless; the plain fact is that the present system is ungovernable. We do think, however, that one problem should be put in perspective. The changes we propose will reduce the visibility that separate authorizations for each problem provided. This will lead to charges of sell-out. In fact, the consolidated authorities will specifically enumerate problem areas, and will be subject to normal legislative and budgetary oversight by the Congress, just as at present but more manageably. For the interest groups, the change is largely cosmetic, since the functions will continue--hopefully on a more effective basis. The only real losers will be the handful of programs and projects which are not viable without special subsidy because they have already failed.

## II. DEVELOPMENT AND DEPLOYMENT OF SKILLED MANPOWER

### A. Introduction and Summary

Skilled Manpower programs increase the capacity of sub-national governments and institutions by influencing the level, mix, composition, and location of manpower needed to provide human services. As in the other parts of this paper, we focus on problems which remain after the effects of our basic programs of financial assistance and the economy they impinge are taken into account. For example, if the doctor shortage were due to consumer inability to pay for some "necessary" level of health care, or to students' inability to pay for graduate education, it would not be a subject of this paper.

The American economy, through the largely uncoordinated training and employment decisions of millions of persons and thousands of institutions, has over the last several decades undergone vast changes in occupational mixes, levels, and locations with what appears to be great overall success in speed and ease of transition. The major current exceptions, teachers and engineers, are as much the result of government action as market forces. And to put the current problem of oversupply among scientists and engineers in perspective, it should be remembered that only 10 years ago the major concern--and one which led to a National Commission and passage of the MDTA--was for "technological" unemployment of the semi-skilled due to automation.

Even with effective overall government manpower policies--such as the loan guarantee and scholarship proposals we make--we would always expect some problems in some sections of the human service manpower market. Students may make incorrect assessments of career opportunities and apply in excessive or insufficient numbers in particular fields, due to ignorance, truly unforeseeable change, or risk aversion. Temporary surpluses lead to unemployment, and temporary shortages to excessive wage rises (and subsequent plateaus because salaries are typically inflexible downward). Training institutions which are often unwilling or unable to expand and contract with labor demand changes increase the length of temporary shortages and surpluses. Finally, professional organizations may act as cartels and create licensing and credentialing barriers in the name of quality control. And past experience suggests that these problems may affect minorities worse than the majority.

The Department currently operates dozens of programs, totalling an estimated \$1.0 billion in FY 74 to deal with such problems. These programs are subject to major criticisms:

- They can hardly be characterized as amounting to a coherent manpower strategy. While the focus has shifted to health from education in recent years, it did so far too late.
- By and large, the programs are not well targeted. Their purposes are not always clear, the need not always justifiable, and in most cases the instruments chosen are inappropriate. We pay people to become doctors, a strategy which would be appropriate only if qualified students were unwilling to do so on their own. Only belatedly have we begun to focus on the major bottleneck--the unwillingness of medical schools to expand to meet applicant demand.
- In many cases a program devoted to one aspect of a manpower problem aggravates another aspect. Thus, the larger the direct and indirect subsidies to medical researchers, the larger the diversion of manpower from primary care and the diversion of medical schools from teaching to research.
- Because the programs spend far more than necessary to achieve social objectives, the excess spending is essentially a windfall subsidy--one which accrues mainly to upper-middle-income people. We could not survive without the social benefits provided by the Army, the Police, teachers and doctors--but this does not justify paying any more than the minimum necessary to meet our manpower needs.

A considerable part--but by no means all--of the existing programs would be justified if we did not reform our student aid programs. Going to medical school is a major expense--both directly and in terms of foregone earnings--and a major risk, even though the rewards for success are great. But with our guaranteed loan program, together with our scholarship programs for low income students, the need for anything like current levels of categorical support disappears.

Accordingly, we propose a major consolidation of existing manpower authorities, together with a substantially reduced level of funding. Because of transition problems, as well as some doubt as to the precise level and types of support that would be justified after the kind of rigorous, detailed research and analysis that must be done, we propose a more gradual phasedown and a higher target level for 1978 (about \$400 million) than we believe a strict application of reasonable criteria for intervention would justify.

## B. Criteria for Federal Manpower Involvement

In a dynamic economy, manpower shortages (imbalances between supply and demand) always will be present. These real shortages will be eliminated in competitive markets over time through wage or employment increases. But sometimes the market is artificially constrained, or demand rises especially sharply, and the time required to eliminate the shortage is lengthy. If through Federal programs the labor supply response could be hastened, social benefits will result because a greater quantity of employment (and service) would result for the same total expenditures. Thus Federal intervention may be appropriate provided that each of the following criteria is met:

- The benefits of Federal intervention must outweigh the costs. This criterion is essentially that which should govern any government action in any field. If children are not learning, or sick people not being cured, then there is a "shortage" of education or health services which may justify action, depending on the effectiveness and costs of tools at our disposal. The difficulties with applying this criterion hardly need elaboration, the crucial point is that a careful and realistic assessment is necessary. For example, if a manpower shortage is due simply to the unavoidable time needed to build up a training pipeline, then actions to subsidize the pipeline have little benefit while actions to hold down wages during the build-up may have substantial benefits. Federal actions are in general likely to be most cost-beneficial in cases in which shortages will persist over a long term or even permanently. This is usually due either to a) deliberate restrictions on entry or mobility, or to b) the existence of substantial social benefits or private costs which are not captured in the wage rate (e.g., rural doctors and exotic language specialists). In such cases, of course, the existence of a social return for some particular type or degree of intervention does not justify any or all possible costs.
- There must be a real manpower shortage rather than lack of customer demand. The hundreds of thousands of unemployed teachers are a dramatic example that government programs to meet "desired" manpower levels by increasing the supply of teachers were misdirected. Real manpower shortages call for manpower programs, lack of effective demand calls for demand stimulating programs. Real shortages will be evidenced by market signals--exceptionally high salaries, relatively large increases in salaries, decreases in job content, increases in job vacancy rates, longer waiting times to acquire the delivered service and other observable phenomena. Of course, the interpretation of these signals is tricky. There are substantial nursing vacancies advertised by hospitals which

might suggest a shortage. However, at the same time hundreds of thousands of RN's are not working as nurses, which suggests that many advertised vacancies do not offer competitive pay or working conditions. Moreover, temporary shortages are desirable as a method of stimulating adjustment and shortage signals alone do not warrant intervention.

- Federal interventions to eliminate manpower shortages must be tailored to the cause of the problem. Federal levers can operate in three areas:
  - a) Applicants--When incorrect student assessments or market imperfections produce a shortage of qualified applicants, Federal policy should be designed to increase their participation. If only certain types of students fail to apply, programs should target on those students.
  - b) Training institutions--When training institutions are unwilling or unable to expand or redirect their programs, Federal institutional support or regulation would be desirable.
  - c) Market place--When qualified applicants are unable or unwilling to work in specific areas and fields, the Federal government needs to consider positive and negative incentives related solely to those places or fields (e.g. G.P.'s vs all M.D.'s).

A policy aimed at one of these areas is likely to have a spillover into the others, and some problems (e.g., G.P. shortages) may require intervention in all three. However, the correct choice of areas is essential if programs are to be efficient.

In what follows we apply these criteria first to health, second to education, and third to social services manpower. Health, for obvious reasons, dominates our discussion.

#### C. Health

##### 1. Overall Supply

It is clear that a substantial expansion in both the demand for and supply of health services will take place over the next decade, even without increased Federal action. Our health insurance proposal will probably provide some net stimulus to demand though the major impact will be on equity and distribution of care. No consequential service shortage is foreseeable, provided manpower is available, except in a few special cases.



Current estimates indicate that despite past shortages adequate manpower will be available on an overall basis in the near future--the data shown below indicate that the number of practitioners will rise substantially over the next eight years. Since population increases will be much smaller, practitioner/population ratios will rise substantially. Moreover, gross manpower projections understate real supply increases since productivity increases should continue

TABLE I

Estimated Projected Increase in Health Manpower  
Professionals: 1970 to 1980

| <u>Health Manpower</u><br><u>Category</u> | <u>1970</u> | <u>1980</u> | <u>Percent Increase</u> |
|-------------------------------------------|-------------|-------------|-------------------------|
| Physicians                                | 323,000     | 424,000     | 31%                     |
| Dentists                                  | 102,000     | 126,000     | 25                      |
| Optometrists                              | 18,000      | 21,000      | 17                      |
| Pharmacists                               | 129,000     | 149,000     | 16                      |
| Podiatrists                               | 7,000       | 8,000       | 14                      |
| Veterinarians                             | 25,000      | 35,000      | 40                      |
| Registered Nurses                         | 723,000     | 993,000     | 37                      |
| Allied Health                             | 2,600,000   | 3,780,000   | 45                      |

Were these data solely the result of unfettered private market forces, in a world without a substantial Federal presence, there would be no case for action except in highly targeted instances. The major question becomes, then, what would be the dimensions of the problems that would be created or remain if all Federal support to health occupations were terminated?

Table II below shows the degree of Federal support.

TABLE II

Estimated Federal Assistance to Health Occupations  
in FY 74 (millions)

|                     | <u>Student Assistance</u> | <u>Institutional Assistance</u> |
|---------------------|---------------------------|---------------------------------|
| Health Professions  | \$61.5                    | \$316.1                         |
| Nurses              | 54.0                      | 66.1                            |
| Allied Health       | 3.8                       | 33.1                            |
| Public Health       | 9.0                       | 12.2                            |
| Health Services     | 12.3                      | 19.0                            |
| Biomedical Research | 108.6                     | 77.7                            |
| Mental Health       | 62.0                      | 36.0                            |
|                     | \$311.2                   | \$560.2                         |

With the income earned by most health professionals at or near the top of the earning potential of all professions and the ready availability of more applicants than there are training positions, there is little justification for large scale Federal subsidization of most students attending health professional schools.



The current employment prospects for those entering the major health professions are well known by individuals making career choices. This is reflected by the rise in the number of applicants. Currently, there are approximately three qualified applicants for each first year place in medicine, dentistry, and veterinary medicine, two qualified applicants for each place in schools of podiatry and optometry, and an equality between applicants and places in schools of pharmacy.

The excessive number of qualified applicants and high earnings in these professions suggest that students could absorb a much larger proportion of the total costs. Just the opposite has occurred over the last decade as medical school tuition and fees as a proportion of the income needed to meet operating expenditures has fallen from 13.0 percent to 8.0 percent.

With regard to registered nurses, there is no aggregate data on the number of applicants versus first year nurse training positions. However, there is no evidence to suggest that a lack of applicants exists. Rather, the rapid expansion in the number of enrollees suggests an adequate applicant pool exists. Over the ten year period 1960-61 to 1970-71, first year enrollment rose from 50,000 to about 80,000.

The one major exception to an adequate supply might be allied health workers, though the growth has been extraordinarily rapid even without major HEW support (There is a considerable Labor Department presence targeted on the disadvantaged). The Bureau of Health Manpower has forecasted an aggregate deficit of 562,000 allied health workers by 1980. However, the American Medical Association, using a more recent trend rate for the supply of allied health workers, predicted no shortage in 1980, but rather a surplus. And there are isolated instances now of unemployment, though this appears to be due primarily to local economic conditions rather than national oversupply. In any event, there appears to be an adequate number of applicants to fill existing programs and stimulate an increase. /

Subsidy of biomedical training has been justified on the basis that if biomedical research is to occur, an adequately trained manpower pool needs to be assured. Such Federal support is justifiable given the length of training if a lack of qualified applicants exists. An adequate pool presently exists with NIH supporting only about one-fifth of all graduate students in the biosciences. While we cannot be certain that a reduction in stipends would not seriously affect the supply of biomedical researchers, declining opportunities in other scientific occupations, e.g., physicists, suggests that this is unlikely.

Mental health stipends go to students in psychiatry, psychology, social work and related fields. Currently, about one-half of all psychiatric residents receive Federal support. Manpower shortages, particularly in State mental hospitals, were the reason for such support. In large part, the psychiatric shortage resulted from the limited incentives of hospitals to have such training programs because of limited insurance coverage for mental illness. Due in part to this special Federal support

and in part to the greater availability of health insurance funds to pay for the treatment of mental illness, the number of filled psychiatric residencies rose from 495 in 1951 to 1388 in 1970. With the growth of community mental health centers and insurance coverage, Federal programs which provide special support for psychiatrists and mental health workers no longer seem necessary.

At least at the present time, therefore, health manpower supply shortages cannot be related to lack of students' interest. Instead, past shortages seem to be related to institutional rigidities. The willingness of health training institutions to voluntarily expand in light of heavy applications varies greatly among institutions. The more complex and expensive the educational training program, the less able is the institution to expand without assistance. For example, allied health institutions are responsive to applicant demand because they do not need a large initial capital investment and tuitions traditionally cover operationing costs.

Medical and dental schools were most reluctant to expand enrollment in the 1960's. From 1960 to 1965 first year medical school places increased by only 100 and dental places by about 250. Expansion is very expensive because these schools, particularly medical schools, must maintain a balance in the quality and quantity of their three outputs (teaching, research, and services). If schools expanded, the tuition received from the increased number of students could not cover the increased costs without substantially higher tuition charges.

Their reluctance to raise tuition is indicated by the fact that quite a few of the medical schools in financial distress over the last few years maintained their tuition charges below that of undergraduates for the same institution and did not look upon tuition increases as an acceptable method of alleviating financial distress. The causes of this seem to be (1) a fear of eliminating the more qualified applicant and (2) a belief that medical school tuitions should be in line with other tuition rates charged at the university. This latter "principle" ignores the fact that doctors make considerably more money than school teachers, and can reasonably be expected to pay for the full costs of their education, like other students.

Unfortunately, with the exception of the capitation grant program and the special educational assistance/special projects program (which account for only \$360 million of the \$870 million dollar support total to health professions), Federal funds subsidizes training rather than provides targeted incentives for training institutions to expand. To the extent that the programs subsidize students by reducing the price of medical training they are misdirected; to the extent that they subsidize inefficient institutions they waste resources. In both cases, tuition is artificially lowered, continued dependency is fostered, and incentives for expansion of numbers of students (as opposed to expansion of costs per student) are minimal.

These observations suggest that Federal support which subsidizes training directly--perhaps as much as \$500 million (which includes direct student assistance and tuition) should be eliminated. The new guaranteed loan program, which provides explicit assurance that no qualified student would be unable to finance his graduate education (even a substantial rise in tuition would not affect total costs very much, since the largest cost is foregone earnings), cements this conclusion. It would be tempered only by the possibility that the applicant pool could drop substantially if current subsidies were eliminated--but it is hard to believe that qualified applications would drop too much (i.e., by half or more), particularly since the phaseout of general training assistance would occur at the same time and reduce the differential that would otherwise emerge. If some schools refuse to raise tuition, and threaten to go under, that outcome may be worth accepting.

## 2. Specific Dimensions of Health Manpower Supply

The conclusions above require tempering. Even without general shortages of health manpower, some specific skill shortages might well remain; and problems of geographic distribution, equality of access, and credentialing might remain. In addition, one specific aspect of doctor training--the overhead costs jointly incurred for research, teaching and patient care--might produce institutional bottlenecks even after students paid the full costs of training alone.

Rather than discuss these problems in detail, we provide some examples below that may justify targeted subsidies:

- Only 30% of present residents are in primary care, versus 49% of practicing physicians in 1960 and 38% in 1970. Clearly, incentives must be changed. We could pay either students or institutions special subsidies to redirect specialization towards such care. Regulation may also be in order. Since many of the current subsidy programs foster increased specialization away from primary care, their abolition would help substantially.
- Current enrollment at medical schools is not representative of the population at large, with only very limited representation of minority female and low-income students. Females and racial minorities each account for less than 12% of professional student bodies (including nursing). Our guaranteed loan program, changing attitudes at large, and civil rights enforcement will all help to change. Nonetheless, targeted aid either to students or institutions to correct such imbalances may be in order, particularly since consumers may be sensitive to the background of service providers. Also, different representation may affect geographic and occupational choice substantially. Possible instruments include direct scholarships and loan forgiveness (though the latter is of doubtful effectiveness).

- Geographic imbalances are also severe. Changes in recruitment may help, and our health insurance package will provide the first truly credible demand support in underserved areas. Nonetheless, special subsidies for location of skilled manpower may continue to be needed. Enlarging the existing National Health Service Corp is a possible approach, as is subsidy directed at location of residency.
- The impediments posed by licensure and credentialing to geographic and occupational mobility are severe. The replacement of licensure by certification may be too radical a move -- but the licensure system can be opened up by requiring relicensure, reducing unnecessarily rigorous standards, and by other regulatory actions. One major possibility is to eliminate the requirement that board examinations be given only to graduates of accredited schools; this may encourage greater innovation in medical education.
- The "joint cost" problem at medical centers is a tough one, particularly since its full dimensions are unknown. Moreover, medical centers as complex as existing ones may not be the best pattern, but reimbursement for overhead costs would reinforce their dominance.

All these problems, taken together, suggest the need for a flexible authority allowing targeting to specific conditions where rigorous analysis justifies intervention. However, total sums involved would be relatively small when compared to existing programs. We are talking tens of millions in each area rather than hundreds of millions.

#### D. Education

The Department currently provides \$83 million for the development of education special manpower -- shown in Table III below.

TABLE III

#### Estimated Assistance to Education Occupations, FY 74 (millions)

|                                    | <u>Student Assistance</u> | <u>Institutional Assistance</u> |
|------------------------------------|---------------------------|---------------------------------|
| Elementary and Secondary           |                           |                                 |
| Special Education Manpower         | \$8                       | \$33                            |
| Adult Education Teacher Training   |                           | 3                               |
| College Libraries                  |                           |                                 |
| Librarian Training                 | 2                         | 2                               |
| Higher Education                   |                           |                                 |
| Language Training and Area Studies |                           | 17                              |
| College Personnel Development      | 7                         |                                 |
| Education Professions Development  |                           |                                 |
| Higher Education Fellowships       | 4                         |                                 |
| Long-Term Training                 |                           | 7                               |
| TOTAL                              | \$21                      | \$62                            |

Sufficiency of education personnel is not a problem at this time; the teacher surplus is large and growing. We estimate that there were 135,000 more new college graduates eligible for initial Teacher certification than full time job openings in public elementary and secondary schools in the Fall of 1972. This surplus of eligibles first appeared in 1967 and is expected to peak at 200,000 in 1977. The cumulative number of surplus eligibles with teaching credentials since 1967 is about 380,000 now and is expected to rise to over a million by 1976.

The evidence on surplus or shortages of teachers in various educational specialties -- teaching of the handicapped, vocational education, math, science, early childhood education -- and in various geographic localities, is unclear. These shortages are decreasing as a result of the overall surplus and many special training programs at the State and local levels. In addition, numerous analysts have pointed out that shortages in these special skill areas have existed because school districts have not been willing to pay for specialized training or enough to match the higher salaries available in private institutions. Teacher salaries have risen rapidly in recent years, diminishing this gap and resulting in more efficient allocation of manpower resources.

Data on equity in minority representation in the profession indicate that there is a shortage of minority teachers. Spanish speaking, Indian and (at least in the North) Black teachers are seriously underrepresented compared to the minority group proportions in the student population. This underrepresentation may hurt the achievement of minority students. At the same time, however, there are substantially greater numbers of individuals from minority backgrounds graduating from college with teaching certificates. This is not a true shortage to be addressed by manpower policies, but a regulatory problem. The lack of new job openings resulting from the general surplus makes it very difficult to increase minority proportions without displacing existing teachers.

While programs to induce higher aggregate enrollments are clearly out of order, and State support will maintain an adequate teacher training base, we see some reason to have levers to upgrade the quality of teacher training institutions. For example, new models of practice teaching are needed, providing for prospective teachers to spend substantial periods working in schools while still affiliated with their training institution. Such incentives need not increase aggregate capacity for teacher training. Indeed, we might conceivably make reduced enrollments one of the conditions for receiving aid--a tactic the precise opposition of that for medical schools.

The foregoing analysis suggests that the current level of \$83 million in support for professional training in education is largely unnecessary, even were it well targeted, and should be phased down substantially.

#### C. Social Services

We currently provide approximately \$45 million in support for training in the social service occupations, as shown below.

TABLE IV

Estimated Support Levels for Social Service Occupations  
FY 74 (millions)

|                             | <u>Student Assistance</u> | <u>Institutional Assistance</u> |
|-----------------------------|---------------------------|---------------------------------|
| Rehabilitation Training     | \$18.1                    | \$ 9.1                          |
| Community Services Training | 4.9                       | 4.7                             |
| Aging Services Training     | 3.3                       | 4.5                             |
|                             | <u>\$26.3</u>             | <u>\$18.3</u>                   |

There is no data that clearly indicates whether there is or is not a shortage of social workers. We do know, however, that the market for social services workers is constrained and noncompetitive. Within the public agencies, the two most significant constraints to competition are the interrelated merit systems and the various credentialling requirements.

The state merit systems may lead to wage rigidity and failure to attract qualified workers. Reinforced by credentialling barriers which at present effectively prevent inter-state mobility, social workers may be severely constrained and exploited by "monopolistic" state employers. These considerations are, however, of unproven real world importance. Many of them apply to all government employees, including teachers. Absent compelling evidence to the contrary, we conclude that training subsidies to induce new workers are not needed. Indeed, such subsidies would reduce pressure on state agencies to correct wage structures. Excessive credentialling barriers, however, should be a target if for no other reason than the fostering of choice and responsiveness.

Other factors do not seem to warrant substantial support. First, the field of social services training is much less capital intensive than health. Consequently, tuition in this area can more easily offset costs. Second, construction and expansion costs, where necessary, can be met by the market and service development program which provides a capital market for this purpose. Third, social services training institutions have adopted fairly well to innovation and new teaching techniques. Finally, during the 1960's the schools increased output rapidly as demand increased; we do not expect nearly so rapid growth in the 1970's.

In sum, the current level of support for social services professions does not appear necessary, nor authority sufficient to correct existing problems. We propose a substantial reduction.



## E. Proposals

The preceding analysis suggests the need for new authorities more realistically targeted to the causes of real shortages problems than at present. Such authorities would include regulatory powers addressed to licensure and credentialing, and would provide broad powers to provide grants related to the special distributional and related problems that we have discussed. They would, moreover, prohibit general training support (either directly to students or through institutions) not directly tied to specific entitlement requirements laid down case by case. The operating mode would be project oriented and explicitly temporary. Major thrusts would require in-depth justification and annual reassessment in terms of the criteria discussed earlier.

Where recruitment of manpower is a problem, the Secretary would have the authority to increase the period of BOG eligibility beyond the undergraduate level. In addition, the Secretary could increase the amount of the loan guarantee if that proved to be a barrier to training recruitment. An appropriate mix of guaranteed loans and grants could, therefore, be developed for each recruitment shortage area.

Where lack of training opportunities was the problem the comprehensive authority would permit the Secretary to provide capitation payments as an incentive to expand training slots. Special project grants would be used to encourage changes in training methods.

Where access to services was a problem, the Secretary would be able to invoke a set of incentives to improve the situation. This could take the form of loan forgiveness, if that proves to be an effective instrument, or payments to practitioners which would lead to the desired distribution of trained manpower. The new authority would also give the Department the power to regulate licensure and accreditation.

We propose that separate authorities (each comprehensive and with the characteristics discussed above) be enacted for health, education, and social service manpower. A broader option, and one with government-wide implications beyond the scope of this analysis, would be to have a single authority covering all occupations and providing for explicit tradeoffs among professions.

In order to solve the transition problem for medical schools, and in view of the substantial uncertainty about the precise effects of major cuts in this area, we propose to retain a specific capitation program.

We propose the following budget levels:

- In health,

- A reduction in the rate of medical school capitation reimbursement annually down from an FY 74 level of \$220 million to \$180 by FY 78. While the level of capitation support is reduced, no school would be permitted to receive any funds if it cut back its enrollment.



- A substantial reduction in other forms of institutional support from approximately \$340 annually down to approximately \$120 million annually. The lower level of support would be designed principally to target on particular shortage fields and to support innovation and other training improvements.
- A substantial reduction in student assistance from \$311 million to approximately \$55 million in FY 78, primarily for special health training scholarship programs for low income and minority groups.
- In education, a reduction in all forms of support from \$83 million in FY 74 to \$20 million in FY 78. The reduced level of support would be primarily in the form of incentives for institutional innovation and improvement.
- In social services, a reduction from \$45 million in FY 74 to \$10 million in FY 78.

### III. MARKET AND SERVICES DEVELOPMENT

#### A. Introduction and Summary

Market and Services Development (MSD) programs seek to improve the performance of institutions which provide human resource goods and services, given some level of effective demand. The concept covers both public and private service deliverers--markets handled either through the price mechanism or through taxes and appropriations. In some larger sense, all our problems of financial assistance to individuals or States are MSD; this paper concerns itself only with the supply and delivery problems that these broad demand-stimulating programs may create or fail to solve.

The MSD programs seek to bridge the gap between our aspirations for the performance of human resource services and the often dismal reality of service delivery. Lack of organizational accountability for larger consequences of actions, ignorance on the part of either consumers or providers, unresponsive bureaucratic organizations, and other "market imperfections" are root causes of inefficiency in service production or failure even to provide needed services which MSD programs attempt to overcome. The programs seek to export not only newly proven techniques (in which cases they overlap with R&D), but also to redirect existing service delivery systems which fail to use current resources and current techniques to meet client needs, and to create new delivery mechanisms where reform of existing mechanisms would be insufficient.

HEW now has a large number of programs which have such developmental objectives. These programs, with few exceptions, have been authorized on a problem-by-problem basis, and provide authority not only for MSD but also for continuing service delivery and/or research. In most cases, they fail to perform any of these functions well -- the most common syndrome is a thinly disguised service program which continues indefinitely for a favored few places and encourages continued dependency on the Federal government. Often the program is poorly designed and fails to create real change -- a massive infusion of resources can be a barrier to change and a reward for continuing past practices when the real need is to redirect existing resources. Meanwhile, other problems and other places do without.

For many of these programs, the major problem is lack of resources and we propose to consolidate authorities into better targeted programs of financial assistance to individuals or states. For most of the remainder, we propose a much stricter approach to MSD -- an approach which recognizes that:

- We can manage and target better our development activities by divorcing them from service subsidies and clarifying their purposes.
- If we are prepared to continue resource supplementation indefinitely we will have to do so long after developmental objectives have been either achieved or failed.
- We do not now have considered strategies for either means or purposes of many MSD programs, let alone the activity as a whole. Some priorities have been missed completely, others are addressed inefficiently.
- The current practice of creating separate authorities and organizations for each MSD activity aggravates our inability to pursue carefully targeted strategies responsive to changing conditions.

To solve these problems, we propose creation of five functional authorities which will consolidate existing scattered MSD activities in elementary and secondary education, higher education, health, social services, and service integration. We also propose a general loan guarantee authority to cover capital costs of public facilities. These functional authorities would recognize the diversity of service delivery problems and opportunities in different service sectors by focusing, as appropriate, on particular target groups and particular problems.

Most crucial would be the features that these authorities would have in common. Because market and delivery problems are often idiosyncratic and multifaceted, and always require a careful selection of levers to promote change, the consolidated packages would be flexible, providing project grant and direct operating authority for technical assistance, retraining, planning, and start-up grants. However, such authorities would be used only for strictly time-limited implementation, of proven techniques which we have good reasons to believe would not be implemented otherwise due to bureaucratic or other impediments, and without continuing subsidy for activities which cannot become self-supporting in their own private or public markets. Even where social benefits are large, instruments would not provide more initial subsidy than the minimum necessary to invoke change.

In the remainder of this paper, we present in more detail the overall rationale for the proposed approach (section B), and specific details on the coverage and priorities within each functional area (section C).

## B. The Proposed Approach to Market and Services Development

### 1. Introduction

To the extent that service gaps simply reflect lack of financial resources, special revenue sharing and financial assistance to individuals will reduce the need for "capacity-building" activities. Nonetheless, a substantial set of public problems will remain no matter how well we assure that command over goods and services in general is adequate. It will often be appropriate for the Federal government to intervene in service delivery when:

- the availability or output of the service, for particular target groups, is too small overall, or in particular geographic areas, and it is unlikely that the non-Federal sector, even with financial capability, will act quickly enough to correct this without Federal involvement;
- the availability of the service may be adequate, but the Federal government may want to influence the character of the service because a new or rarely used delivery mechanism is more effective or less costly, but the non-Federal sector will not act to change;
- a market may simply fail to develop, or work poorly, for a combination of reasons including failure of either suppliers or customers to understand the benefits of the change, or effectively organize to change (e.g., HMO's).

These "market failures" may arise from any number of causes -- lack of knowledge at the delivery level, bureaucratic inertia and sheer resistance to change, lack of congruence between local and national objectives, failure of non-Federal actors to take account of larger consequences (spillovers) of their activities, exercise of monopoly powers (credentialing impediments), and failure of the capital market. Such failures arise not only in private markets, but also (and perhaps more commonly) in public sector provision of goods and services.

Research, independent regulatory activities, and regulation tied to financial assistance are all modes of intervention which may be appropriate in such cases. For example, the State Student Incentive Grant program we discuss in our proposals on higher education uses a financial leverage to redirect state education expenditures away from institutional aid which undercuts private institutions. Therefore, the activities which we term "Market and Services Development" are part of a larger continuum of intervention. We want strictly to limit the term, however, for those time-limited interventions which should be able to achieve their purposes without committing large amounts of Federal resources to supplement or change normal financing sources.

## 2. The Necessary Tools for Effective MSD

The legislation to be developed for MSD purposes will specify substantial flexibility in instruments available to the Secretary. The very diversity of problems, together with widely varying local conditions (bureaucrats are not everywhere resistant to change on all fronts) suggests that a wide variety of instruments are necessary to achieve service development objectives, tailored to specific conditions and problems. Given that the knowledge exists at the Federal level, either because of our research or independent of it, change instruments would include knowledge dissemination, technical assistance, demonstrations, staff training, expansion grants, start-up grants, evaluation, and similar activities alone or in combination. Such tools would be used in-house, through contracts, and through grants, as appropriate. Recipients would include state, local and private institutions. Fees could and in many cases should be charged for assistance.

The program and problem coverage of the legislation would also be comprehensive, by consolidating existing scattered authorities which have MSD objectives. Rather than create a separate narrowly defined categorical program for each educational or health problem, the legislation would specify a wide range of problem areas in which MSD instruments would be used. The specifications would be quite detailed in cases (such as RMO's) in which the activity is so significant that careful legislative tailoring is essential. But all such specifications would be subject to general provisions discussed below. This would provide several benefits.

- MSD priorities could be more directly traded off against each other, in the context of a consistent framework.
- More flexible authority would enable us to overcome leverage gaps and package our tools more precisely to obtain the benefits we want.
- Consolidation would enable us to fill problem gaps which the vicissitudes of the authorization and budget process tend to leave unfilled or fill only belatedly.

Related to the value of consolidation and flexibility, State formulas are inherently inappropriate. We do not want "fair share" grants spread around for each development activity since (a) in many cases the problem will be of different dimensions in different places; (b) the ability to limit costs, coverage and timing is almost impossible to accomplish in formula programs and (c) many of the problems and institutions we will wish to impact are local rather than State, and private rather than public. The problem created by lack of a formula is the common tendency for project monies to concentrate in a few places, partly because of differing grantsmanship and substantive competences at the local level, and partly because we deliberately seek to create centers of excellence or focus. We propose to handle this problem internally by keeping track overall of geographic impact and administratively imposing limitations if problems emerge.

The prohibitions and limitations which the legislation would place on covered activities is as important as the activities that would be allowed. These limitations would have as their principal purpose a self-imposed discipline on MSD activities. For example, an endemic problem occurs because of the temptation to include on-going service provision monies in development programs. This has unfortunate consequences for our ability to ensure that our efforts meet real needs. Almost any service innovation will meet a need and stimulate a great demand if fully subsidized and provided free. We propose that with few exceptions all such programs be strictly time-limited and avoid subsidizing any cost beyond start-up strictly defined. This means, as a practical matter, that if an activity (HMO, health center, reading technique) does not catch on in a particular place after a fair chance, it ends. These restrictions are crucial to:

- Avoid inequitable service subsidies better handled through general financial assistance;
- Discipline those promising programs which simply do not prove themselves once off the drawing boards;
- Free up money each year, as projects are discontinued, for new priorities; and
- Serve as unambiguous advance notice to recipients that any subsidy will be time limited and thereby stimulate their own efforts to provide routine financing from local budgets or service charges.

As a strategic posture, and to avoid misunderstanding, we propose to write such restrictions into law, even in cases where administrative regulations would suffice. In effect, the law will mandate institutional non-dependency. Rather than face the agonizing political and substantive arguments for "just one more year" and "success is just around the corner," we will be forced to answer that our hands are tied. The disadvantage to such a tough policy is that some reforms may only be purchasable if large, continuing service subsidies are provided. In such cases, special revenue sharing with appropriate earmarks, or improved programs of financial assistance to individuals, are the major alternatives and should be used.

Among the kinds of legislative restrictions which we propose are general limitations requiring that for each project:

- No contracts may cover more than three years; may cover more than the annualized equivalent of one year of service costs (including amortized capital costs and recurring operating costs); or may be provided for activities which do not have a substantial probability of becoming self-supporting within three years.
- All contracts must specify the understanding of both parties that project funding is one-time only; must specify the steps that the local party will take within the period of the contract to become self-supporting; and must provide for cancellation and reimbursement if conditions are not met.



The only exceptions to such provisions would be on-going technical assistance, on-going support of planning institutions, and possibly a minor waiver authority for not more than 10% of total funding to cover highly unusual cases.

Additional restrictions will have to be decided through normal Congressional and executive processes, case by case. In some instances, a delivery change may be important enough to warrant hundreds of start-up grants to assure nation-wide extension. In other cases we will want to stop at demonstration in a selected number of sites and thereafter provide no more than limited technical assistance and information dissemination, primarily because automatic nationwide extension can destroy incentives or become extraordinarily expensive. If we are prepared to install a new reading technique or health delivery organization everywhere, it may not be installed anywhere until our assistance is available. But if we make it clear that only 100 school districts or 100 cities will receive a full package of assistance, and the rest must rely on no more than informational assistance, Federal dollars will go much further.

### 3. Activity Mix and Budget Levels for MSD Programs

A major problem in reforming MSD activities is our overall lack of knowledge as to what delivery changes are in fact desirable enough to be worth their implementation cost in specific areas, and lack of knowledge as to how to implement such changes successfully. Most existing programs do not lack for criticism on both counts. In part, this is simply a dynamic problem--we learn by doing and hopefully increase our knowledge over time. In part, we simply lack truly "proven" models to export and always will.

Nonetheless, it is possible to specify areas in which serious problems exist, and in which promising if not fully proven changes are possible. These include at least some of our potpourri of health services delivery instruments, notably HMO's; an endemic set of capital market problems which face many specialized service providers such as hospitals and day care centers; a few educational innovations in programmed learning and the like; markets for food delivery and other specialized needs of older people; improvements in service information systems (e.g., day care); and failure of many institutions to provide appropriate services for particular kinds of problems such as mental retardation, physical handicaps, or cultural differences.

We have, as a first approximation, begun our consideration of MSD activity and budget levels (in Section C) with current types and levels of spending on existing programs which more or less meet our MSD criteria. Wherever possible, we have modified these levels to reflect savings which would result from restriction to start-up costs without service subsidies, lack of proven knowledge or managerial capability, or foreseeable and desirable changes in program levels. What will be ultimately essential is to develop rather detailed implementation strategies problem-by-problem. Meanwhile, our proposals envision some expansion in numbers and types of projects, though at somewhat lower budgetary costs as service subsidies are eliminated.

C. Details by Functional Area for Market and Service Development Proposals

In what follows we deal with coverage, priorities, size and management for the programs we propose, as contrasted to existing MSD programs. Development of precise program plans will be of critical importance at some point, for now the best we can do is provide a tentative and in some cases strictly illustrative outline, focusing on transition problems.

We do not include in our figures, or discuss in detail, the costs and tasks of HEW employees who will administer these activities. Proper management will probably not be possible with any substantial reductions in current staffing, and may require additional positions in some cases. Planning, advocacy, audit, evaluation, analysis and technical assistance--the jobs of management--will continue to be crucial to success in inherently labor intensive MSD programs. The proposals we make are necessary but not sufficient to improve the conduct of these activities--clarification of purpose and shedding of service subsidy objectives will enable, but not force, improved management.

1. Loan Guarantees for Public Facilities

We propose government creation of an insured capital market for "public" buildings, a market which could break even (as does FHA) by charging a small loan premium (but over private market rates to avoid service subsidy) and avoid the need for creation of special purpose facility support. Existing HEW authorities for facilities loans and grants (most of which are shown in the table below) would be repealed. Our program would operate on a break-even basis with no net budgetary costs.<sup>1/</sup> Its design would be similar to the recently enacted Academic Facilities Loan Insurance program but extended to facilities for education, health, and social services.

<sup>1/</sup> Some obligations and outlays for existing programs would continue due to prior commitments.

TABLE V

MAJOR HEW FACILITIES GRANT AND LOAN PROGRAMS  
(budget authority in millions)

| Item                                                                 | 1974 DHEW<br>Budget Estimate |
|----------------------------------------------------------------------|------------------------------|
| <hr/>                                                                |                              |
| OE:                                                                  |                              |
| Public Library Construction                                          | \$ 0                         |
| Higher Education Construction grants &<br>subsidized loans <u>1/</u> | 30                           |
| Higher Education Facilities Loan and<br>Insurance Fund <u>1/</u>     | 5                            |
| Academic Facilities Loan Insurance                                   | 0                            |
| SRS:                                                                 |                              |
| Rehabilitation facility improvement grants                           | 13                           |
| Special Institutions:                                                |                              |
| Separate construction programs <u>1/</u>                             | 22                           |
| HSMHA:                                                               |                              |
| Mental Health Center Construction                                    | 0                            |
| Health Services medical facilities<br>(Hill-Burton)                  | 85                           |
| Medical facilities guarantee and loan fund                           | 0                            |
| NIH:                                                                 |                              |
| Health Manpower construction assistance <u>1/</u>                    | 82                           |
| Start-up and conversion assistance <u>1/</u>                         | 8                            |
| Total <u>2/</u>                                                      | <hr/> <hr/> 245              |

1/ Suggested for abolition or phaseout in proposals in other papers as well.

2/ Excludes other agency programs which could be candidates as well (e.g., HUD college dormitory program).

As other papers have argued, the elimination of overt interest subsidy or outright grants (e.g., for hospitals and universities) would be defended principally on the ground that we are now handling the demand side much better and need not support even worthy beneficiaries at the expense of the public at large--but this new program would help assure that supply will in fact be forthcoming. Even if current capital subsidies were not all eliminated we would at least assure that no other activity was deprived of a capital market merely because its lobby was less adept, and reduce the pressure for new authorities. While the program would hardly be a credible alternative to the subsidy provided by tax-free status of State and local bonds (these bonds would not be insured), it would tend to reduce the pressures to finance heretofore private facilities such as hospitals through leaseback arrangements using local bonds.

Such a program would have substantial merit in its own right simply because many providers of "public" services face substantial problems in obtaining private capital to finance construction or renovation of special purpose buildings--college dormitories and classrooms, hospitals, medical schools, neighborhood centers, day care centers, and the like. Since facilities costs are often a major drain on initial cash flow, this can be a crippling problem. Financing problems are due in part to the doubtful return on such projects and, unlike homes, a frequent lack of alternate users to whom lenders could sell in case of foreclosure. In addition, while bankers can and do foreclose on homes routinely, foreclosing on a local hospital is a major political act and one which few bankers would be willing to contemplate.

The guarantee would present a number of design problems. For example, what is a "public" facility--is there any way to cover proprietary institutions in direct competition with public institutions without opening the gates to "Lockheeds" and New England shoe factories? Should we cover initial operating as well as facilities costs--and if so when would this program be used in lieu of start-up grants under our functional authorities? On the other hand, it would simplify the operation of many or most grant programs, since these programs would simply include sufficient funds for rent (or mortgage) as well as other operating costs and avoid the crazy patch-quilt of construction and renovation authorities which we now feel impelled to include. This would, in addition, reduce outright budget costs in many such programs.

The largest issue, and one beyond the scope of our analysis, is whether such a program should go beyond the purview of HEW-type services facilities. Should it be government-wide and cover transportation and sewage? Would it be useful in a tax reform package?

## 2. Post-Secondary Education

Unlike any other major functional area except health, higher education is substantially private rather than public. Unlike even health, the market is inherently national rather than local. For these reasons, Federal encouragement of State and local omnibus planning, and a conscious strategy of working through State bodies, seems inappropriate. Moreover, most State and local governments do not take account of the adverse spill-overs of their current policies. <sup>1/</sup>

Higher education is farther along in MSD than other functional areas, since convergent thinking over the last several years concerning the need for reform and reassessment has led to the recent enactment of a post-secondary innovation authority, which essentially meets our MSD concept. It is a consolidated, comprehensive authority providing wide latitude in conducting activities to improve the post-secondary market. It will focus most intensively on reducing the fundamental institutional rigidities of a system which is largely tied to the campus, classroom-lecture, professionalization, sequential-attendance model. It is also concerned with the accommodation of the system to a broader range of human needs, especially disadvantaged entrants and middle-aged non-entrants. Finally, the program's purview includes questions of credentialing and accreditation. However, the legislation does not include the restrictions on continuing service subsidies that we propose.

In addition to this authority, there are other post-secondary programs which have nominal MSD purposes, as shown in the table below:

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<sup>1/</sup> Discussed in detail in the Student Assistance paper.

TABLE VI

NEW DEVELOPMENTAL POST-SECONDARY PROGRAMS  
(budget authority in millions)

| <u>Programs 1/</u>                            | <u>1974 DHEW Budget Estimate</u> |
|-----------------------------------------------|----------------------------------|
| Post-Secondary Innovation                     | \$ 50                            |
| College Library Demonstrations                | 2                                |
| Higher Education Institutes (EPDA)            | 8                                |
| Upward Bound                                  | .44                              |
| Special Services                              | 35                               |
| State Post-Secondary Education<br>Commissions | 8                                |
| <b>Total</b>                                  | <u>\$147</u>                     |

1/ The Black Colleges, Work Study and Cooperative Education programs also have developmental objectives but are primarily service programs and are discussed in the Student Assistance paper.

The library demonstrations and higher education institutes are virtually identical in purpose and activities to the innovation authority and we propose direct incorporation of their functions into the innovation authority. It is not clear that Post-secondary Education Commissions perform a planning function of continuing importance, since unlike health and other functional areas, the most important planning and utilization problems are nationwide rather than local. We propose to discontinue supporting this function, although the innovation authority would also be able to provide temporary assistance related to State and local planning.

The programs for disadvantaged students, Upward Bound and Special Services, duplicate the new authority in purpose, but have become primarily continuing service programs in a limited number of places. We propose a rapid phase out of existing contracts. If existing recipients do not assume the burden the programs will have failed. In most cases we expect that the programs will have effected permanent changes and fulfilled their developmental function. New projects in this area will be assumed under the innovation authority and our rigorous MSD criteria.

These changes would be accomplished by amending the innovation authority, effective in FY 74, to incorporate our limitations and repeal the other authorities. We expect the obligation level to rise to \$75 million in FY 74 and continue at that level through FY 78. No FY 74 obligations would be made under the old authorities.

### 3. Social Services

We propose to create a new consolidated MSD authority for Social Services. Existing authorities with primary MSD purposes would be repealed, effective in FY 74. They are shown in the table below:

TABLE VII

#### SOCIAL SERVICES MSD PROGRAMS (budget authority in millions)

| <u>Item</u>                                                 | <u>FY 1974 DHEW Budget Estimate</u> |
|-------------------------------------------------------------|-------------------------------------|
| Development Disabilities<br>Service Projects                | \$ 18                               |
| Aging, Area-wide Projects                                   | 54                                  |
| Youth Development and Delinquency<br>Prevention             | 15                                  |
| National Center for Deaf-Blind                              | 1                                   |
| Head Start Demonstration and<br>Related Activities          | 35                                  |
| Vocational Rehabilitation<br>Service Projects <sup>1/</sup> | 53                                  |
|                                                             | <u>\$ 176</u>                       |

<sup>1/</sup> Excludes \$13 million for construction grants reflected in Table II.



The new program would provide for essentially the same kinds of problem area/target group coverage as the existing programs--child development, juvenile delinquency, physical and mental disabilities, and problems of aging. Like the existing programs, it would focus on demonstrations of innovations in service delivery, encouragement of more responsive community organizations, and the like. It would work primarily with State and local government service agencies, but also with the extensive and potentially larger private sector (both volunteer and for-profit).

We would expect the new program to fill gaps not now met well. For example, there is increasing evidence that center-based day care does not appeal to parents of young children (even highly subsidized centers often cannot fill their slots), and we know that the preferred family and in-home arrangements are frequently unstable. Such problems suggest the need for an initiative to provide technical assistance and seed money to communities to improve their day care plans and to encourage a focus on self-supporting, fee charging, information clearing houses for mothers and existing providers. Similarly, the greatest demand is for after-school care for older children, but the vast range of organizations (Scouts, Y's, Boys' Clubs, etc.) now providing programs for children out-of-school ought to be tapped or organized in the day care context.

In addition, our aging programs have hardly begun to stimulate private and community organizations to use their own resources to deliver food and other services targeted to the special needs of the elderly. Finally, and perhaps most neglected now, there would be a major role in exporting to State and local social welfare organizations better management techniques--better caseworker methods (such as those of the V.R. program), organizational models, new functions such as "ombudsmen", workable fee systems, and the like.

The major change from existing arrangements would be the prohibition on continuing service subsidies in these developmental programs. In particular, most of the existing V.R. service projects are primarily budgetary additions to the basic budget. We estimate that a total program level of \$150 million for FY 74 and thereafter would allow some increase in the geographic coverage and kinds of projects attempted.

#### 4. Elementary and Secondary Education

Elementary and Secondary Education is primarily supplied through public markets--State and locally operated school districts. While the Mills-Carey Bill or a similar program will likely have some impact on the viability of private schools, this or any similar approach is really a marginal endeavor so long as we do not go to full voucher system. Therefore, most promising MSD options lie in programs designed to change and improve the public schools use of their resources.

We propose a single, consolidated MSD authority to replace the programs listed below:

TABLE VIII

ELEMENTARY AND SECONDARY EDUCATION  
DEVELOPMENTAL ACTIVITIES  
(budget authority in millions)

| <u>Item</u>                                                            | <u>1974 DHEW Budget Estimate</u> |
|------------------------------------------------------------------------|----------------------------------|
| Bilingual Education (ESEA III)                                         | \$ 51                            |
| Special Projects for Indian Education                                  | 6                                |
| Education for the Handicapped                                          |                                  |
| Special Target Programs                                                | 38                               |
| Technology and Communication                                           | 15                               |
| Career Education                                                       | 14                               |
| Adult Education Special Projects and Teacher Training                  | 12                               |
| Talent Search                                                          | 7                                |
| Teacher Corps                                                          | 38                               |
| Elementary & Secondary Development                                     | 61                               |
| Vocational Education Development                                       | 14                               |
| New Careers in Education                                               | --                               |
| Educational Technology Demonstrations (Sesame Street and others)       | 36                               |
| "National Priority" programs (Right to Read, Dropout Prevention, etc.) | 39                               |
| Educational Renewal                                                    | 2                                |
| Total                                                                  | <u>\$ 333</u>                    |

Elementary and secondary education is perhaps the clearest case in which the current proliferation of quasi-developmental programs has hampered change as much as encouraged it. Most of these programs are now operated under carefully and differently restrictive authorities (in some cases formulas), and wind up as continuing financial support without rhyme or reason.

These problems are compounded because the structure of our public education system discourages the introduction of new techniques. It is a locally centralized, non-competitive bureaucracy with little inter-district communication and with great internal pressures against change. The individual education manager--administrator, superintendent, principal or teacher--has his hands tied by curriculum limitations, the school board, the union, purchasing requisitions, and personnel regulations. Moreover, he has little incentive to change. New techniques have a low probability of adoption because they are complex, costly and risky.

An administrator or teacher willing to change needs to know what changes would be most productive. Unfortunately, little such knowledge now exists. NIE is the key instrument on the knowledge front. But even when knowledge exists, incentives for change in both instructional processes and management must be developed. This requires a comprehensive and reorganized approach to Federal demonstration, dissemination, and technical assistance activities.

Whatever techniques of implementation we use, local reform should be based on validated instructional and management practices produced by NIE and others. Few such techniques now exist, though there are a number of promising examples which are either more effective or less costly (e.g., Sesame Street and other broadcast techniques). Other changes, such as improved accounting or planning processes, do not require extensive research though we find it difficult to develop successful implementation techniques. (Unlike other areas, here we do not need an additional planning support authority since large and small planning organizations already exist. The problem is to improve their effectiveness.) A final category of changes revolves around assistance to deal with upheavals caused by e.g., desegregation and continuing problem areas such as assuring that non-English speaking children are not abused or ignored. One such area which we largely ignore at this time is technical assistance related to compensatory education.

Without attempting to specify desirable changes in either implementation techniques or priority mix among the programs, it seems obvious that the critical impact of our proposal will be on OE-LEA expectations. For example, the bilingual problem could be viewed as one of resources,

and the current program is primarily a resource supplement to a lucky group of school districts. It has been estimated that its expansion nationwide would cost half a billion dollars. Instead, under our MSD approach, the bilingual problem becomes a more manageable one: influence the use of existing resources (especially the billions in supplemental funds for the disadvantaged under revenue sharing) to bring about permanent changes in teaching staff and techniques to meet the special needs of bilingual children.

Where necessary, assist the school with the necessary costs of change--but in no cases fund, as an extra supplement, continuing salary costs through a nominally developmental program, and do not allow school districts to expect automatic funding of their proposals (the ones most likely to request help are often the ones most able and willing to change on their own).

We estimate that \$300 million annually, from FY 1974 through 1978, without continuing service subsidy, would allow some expansion in current approaches for developmental activities.

#### 5. Health Services

We propose creation of a single, consolidated authority for projects to improve the supply, access, utilization, efficiency, and quality of health services. More than in any other area, existing programs for improving the health delivery system combine service subsidies with truly developmental change costs. The bulk of the existing budget in this area is for continuation grants to projects which were supposed to become self-supporting but have not been able to get direct or third party reimbursement for their services. Our health insurance proposal will solve this problem; pending its assumed effective date (FY 1976) we propose to refund these projects. The table below provides rough estimates of the developmental portion of these programs:

TABLE IX

HEALTH DEVELOPMENTAL ACTIVITIES  
(budget authority in millions)

| <u>Item</u>                                                                                                   | <u>1974 DHEW<br/>Budget Estimate</u> | <u>1974 Developmental<br/>Portion</u> |
|---------------------------------------------------------------------------------------------------------------|--------------------------------------|---------------------------------------|
| Community Mental Health<br>Centers & Mental Health<br>of Children                                             | \$ 151                               | \$ 30                                 |
| Drug Abuse Project Grants <u>1/</u>                                                                           | 139                                  | 25                                    |
| Alcoholism Project Grant <u>1/</u>                                                                            | 56                                   | 16                                    |
| Health Maintenance Organi-<br>zations                                                                         | 60                                   | 60                                    |
| Hill-Burton <u>2/</u>                                                                                         | (85)                                 | (0)                                   |
| Comprehensive Health Services<br>project grants and migrant<br>health grants                                  | 139                                  | 28                                    |
| Maternal and Child Health<br>grants to states                                                                 | 225                                  | 45                                    |
| Family Planning Services                                                                                      | 154                                  | 31                                    |
| Community Environmental<br>Management (NEEDS)                                                                 | 1                                    | 1                                     |
| Comprehensive Health Planning<br>(CHP)                                                                        | 59                                   | 54                                    |
| Regional Medical Programs<br>(including Emergency Medical<br>Services and other technology<br>demonstrations) | 100                                  | 100                                   |
| TOTAL                                                                                                         | \$1,084                              | \$ 390                                |

1/ Service funds revenue-shared rather than cashed out to health insurance

2/ Non-add because already counted in facilities totals in section B. 1 above.

We expect the general mix and focus of the developmental portions of these activities to remain roughly the same, with somewhat more emphasis given in the latter part of the decade to improvements in existing institutions as the wave of "comprehensive" projects subsides (i.e., HMO's are to become a widely available alternative, not a replacement). To a greater degree than at present we expect to focus on underserved areas in new projects.

The highest priority will be given to the development of CHP agencies as vehicles to plan facilities utilization and delivery improvements in each community, primarily to control burgeoning medical costs related to inefficient and wasteful proliferation of costly and duplicative services. Existing RMP agencies will be redirected to serve implementation and technical assistance functions related to such plans.

The consolidated legislation we propose to replace existing authorities will take effect in FY 1974, authorizing project activities under strict MSD criteria, as well as continuing support for planning and implementation activities. We propose a 1974 budget level of \$350 million, exclusive of the continuing cost of supporting existing projects during transition. (By 1978, we expect to transfer funding of CHP activities to a user charge on private health insurance or possibly to revenue sharing).

#### 6. Services Integration

One major class of delivery innovation that we want to see spread is that which relates to customer convenience of access, comprehensiveness of treatment, and cost savings for services and problems that cross "functional" lines. The Allied Services Act, budgeted for \$20 million in 1974, is currently proposed for enactment. We propose that the services integration authority be rewritten to comply with our MSD criteria and re-submitted.

The new program would have a somewhat narrower focus than the existing proposal, since many of the Act's purposes would be accomplished by other proposals. In other respects it would be broader, focusing on private as well as public service deliverers and allowing, for example, projects related to cross-cutting technologies such as telecommunications.

Finally, we see functional and regional office staffs of DHEW performing (much as they do now, but more focused) a technical assistance and implementation role for MSD projects. In some cases this means working with State agencies, in others, working directly with local or private agencies. Whether or not this whole area of activity should be rationalized as a "human services extension agency" approach is a subject for further analysis, along with organizational and staffing needs in general.

#### IV. RESEARCH AND DEVELOPMENT

This part of the paper specifies the parameters of the Research and Development (R&D) component of capacity building. R&D refers to activities whose purpose is to produce "new" knowledge. Included are research, experimentation, some evaluation and demonstration. These activities are to be distinguished from more active efforts to bring about change at sub-national levels based on knowledge discovered by research. These "change producing" activities are addressed in the previous section.

We propose here that the Department's R&D activities be placed under tight control by explicit inclusion in five consolidated R&D authorizations, managed by research organizations and traded off against other research programs in terms of their knowledge creating ability. Biomedical research would be largely unaffected by our proposed reforms.



A. The Federal Role in R&D

The principles which demand a reduced Federal role in many HEW activities do not suggest any similar shift in the Federal role with respect to research and development activities. The Federal government should remain the primary funding source and resource allocator for R&D activities for three reasons.

1. The product of research and development activities usually is knowledge. The producer of knowledge often cannot sell his product for what it is worth. Potential users of the knowledge product, unlike most products, need only see the product or hear of it to have it. Thus, while a new piece of knowledge may have great value--the aggregate of small value to a number of users--it may not have sufficient value to any one user to justify that user's investment of the resource necessary to produce it. Accordingly, there will be too little investment in the development of new knowledge unless all the potential investors in knowledge can be made to act jointly. The Federal government can bring about such joint investment by simply using tax dollars. For this reason the Federal government might invest in the development of an understanding of how the brain works although a private firm would not, since this knowledge would be likely to become available to the firm's competitors for free. Similarly, the Federal government might pay to find out about the effectiveness of a new kind of education paraprofessional although a single school system would not, since it would be unable to charge other school systems which might use the knowledge to share the cost of its discovery.
2. Even if the aggregate investment in research were established--for instance, by the distribution among the States of Federal funds earmarked for research--these resources might not be devoted to the most important R&D unless the Federal government also specified the subjects of R&D. Each State, for instance, would be biased toward studying subjects of peculiar interest to it, since studying subjects of broader generalizability would simply benefit other States which had not shared in the investment.

3. Although it would be possible for a large number of independent parties--for instance, States or private firms--to coordinate with one another so that each would not do the same R&D, it may be convenient to have the Federal government play this coordinating function by assuming resource allocation responsibility for all R&D.

B. Organization and Management of R&D

These considerations not only argue for a continued strong Federal role in R&D, they indicate that the current Federal role should be strengthened. High quality research, much of it in the form of careful experimentation is the cornerstone of Federal capacity building efforts. To this end, we propose several improvements in R&D management.

When Federal resources are intended to be devoted to the creation of new knowledge, it is important to define clearly both the subject to be studied and the method to be used. Where ambiguity exists, recipients of Federal funds tend to use the funds to serve their own needs at the expense of generalizable knowledge. Such ambiguity has been allowed to exist in a number of the Department's programs. We have proposed in other papers that some of these programs be converted to revenue sharing--e.g., ESEA Title III. We propose here that a number of fragmented R&D programs be placed under tighter controls by explicit inclusion in larger R&D authorities.

Such consolidation permits better coordination among projects, allows a broader range of trade-offs among candidates for R&D funding, and permits tighter management of R&D efforts by subjecting projects to review and competition within an R&D organization. The concern about linkages between R&D and operating programs disappear when the operating programs are revenue shared.

Table I below shows the six proposed R&D authorities.

TABLE X

RESEARCH AND DEVELOPMENT PROGRAMS

|                                       | Current FY 74<br>Funding Level<br>(millions) |
|---------------------------------------|----------------------------------------------|
| <u>Mental Health R&amp;D</u>          |                                              |
| 1. General Mental Health              | \$ 75                                        |
| 2. Drug Abuse Research                | 11                                           |
| 3. Alcoholism Research                | 8                                            |
| Subtotal                              | 94                                           |
| <u>Health Services R&amp;D</u>        |                                              |
| 1. Health Services R&D                | 70                                           |
| 2. Maternal and Child Health          | 6                                            |
| 3. Health Manpower                    | 18a/                                         |
| 4. Family Planning                    | 4                                            |
| 5. Disease Control                    | 2                                            |
| 6. Community Environmental Management | 2                                            |
| 7. Scientific Activities Overseas     | 7                                            |
| 8. Occupational Health                | 3                                            |
| Subtotal                              | 112                                          |
| <u>Biomedical R&amp;D</u>             | 1,487                                        |
| <u>Education R&amp;D</u>              |                                              |
| 1. Follow Through                     | \$ 41                                        |
| 2. Education of the Handicapped       | 14                                           |
| 3. Adult Education                    | 2                                            |
| 4. Education Activities Overseas      | 3                                            |
| 5. National Institute of Education    | 156                                          |
| Subtotal                              | 216                                          |
| <u>Social Services R&amp;D</u>        |                                              |
| 1. Social and Rehabilitation Services | \$ 52                                        |
| 2. University Affiliated Facilities   | 4                                            |
| 3. Research Overseas                  | 8                                            |
| 4. Child Development                  | 13                                           |
| Subtotal                              | 77                                           |
| <u>Income Maintenance R&amp;D</u>     |                                              |
| 1. Social and Health Insurance        | \$ 21b/                                      |
| 2. Income Maintenance Experiments     | 11                                           |
| Subtotal                              | 32                                           |
| Grand Total R&D                       | \$2,018                                      |

a/ Found in direct operations portion of the budget.

b/ Contained in OASDI and HI.

As the table indicates, we combine the Maternal and Child Health, Family Planning, Disease Control and Occupational Health R&D programs with the Health Services R&D program, since the operating programs to which the former R&D programs attach will be either revenue shared or picked up by health insurance. We also place Health Manpower R&D into this package on the assumption that our health manpower program will probably be run by the same organization that would be responsible for managing market and services development and revenue sharing programs; thus, the need for a separate health manpower R&D program to assure linkages to NIH is not necessary.

Similarly, Follow Through, Education of the Handicapped Research and Adult Education Research are put into the same authorization and organization as NIE when their related operating programs are revenue shared. Finally, with Head Start revenue shared, several Child Development experimental programs and the Child Development R&D program are to be combined with the current SRS R&D program.

We do not propose further consolidation of the six R&D activities shown in Table X--for instance, into a single authorization and organization--because such a change would reduce the extent of linkages to operating programs. But we think further possible consolidations should be a subject for future HEW consolidation.

We also propose to improve planning and management within the six R&D authorities/organizations by: (1) improving R&D planning; (2) establishing procedures to maintain technical quality of projects; (3) designing procedures to disseminate project results to State and local governments; and (4) eliminating R&D demonstrations that are really service providing activities.

#### C. The Content of R&D

Despite the shifting of much of HEW's program management responsibilities to State, local or private decision makers, and the consolidation of R&D programs, we see no significant change in the substance of HEW's research--assuming we are now doing the research appropriate to our current program management roles. To illustrate, a basic program design/management question for HEW in its current roles might be whether to expand the use of work evaluation services under the Vocational Rehabilitation program; Federal research programs should now be addressing this question. If vocational rehabilitation were simply an optional program which the States could choose to support with revenue-sharing funds, those States making such a choice would need to know whether to expand their use of work evaluation services; they would quite properly expect a Federally-run research program to address this question.

There are, however, some respects in which the substance of R&D would change in line with the proposed new Federal program management roles. First, research would be needed on the desirability of the new roles and on ways to make them effective. If we move toward maximum liability health insurance, for instance, we will need research on the effectiveness of various inducements to families to purchase preventive services. If we move toward the income assistance and employment program, we will need to know what relative tax rates encourage persons to take "regular" employment and what priorities should be established for training. Thus a greater focus towards consumer preferences.

One particular aspect of research substance might be strongly affected under our health insurance proposals: the extent to which biomedical research works to develop very expensive treatment techniques. Specific policies on this question will need careful examination.

Second, there are some areas where the Federal role in R&D should be reduced. Where it is possible for the producer of new knowledge to capture most of the revenue from that project, there may be little need for Federal support. For example, if curricula developed by a private firm can be protected by copyright laws, it may be preferable for the Federal government to cease supporting curriculum development. HEW needs continually to examine its R&D efforts to identify those where a single party might capture the returns from new knowledge. Where such situations exist, HEW will have to decide whether Federal support should be withdrawn in view of the kind of monopoly pricing a copyright or other form of protection for innovation would permit.

#### D. Funding Levels

There is no major change proposed in funding levels for R&D. We see no reason to expect the proposals we are making in other papers to affect the determination of appropriate total R&D funding level in any particular direction.

E. Relation of R&D to Other Capacity Building Activities

R&D and market and services development activities are difficult to distinguish at the point where R&D results become ready for dissemination. Sometimes it will be desirable to fund projects for two purposes: (1) to test a particular way of providing services in order to create new knowledge; and (2) to create a model which will be available for possible users of the new knowledge to observe if the test indicates that such use is appropriate. In these instances, responsibility for the project might reside in either the R&D or the market and services development area; the two must be closely coordinated. Regardless, with greater reliance on decision by individuals and State and local governments, a major thrust in R&D must be on dissemination of results.

OTHER HEW ACTIVITIES: PLANNING  
ADVOCACY, DATA SYSTEMS AND REGULATION

The previous papers have laid out the major initiatives which are part of the comprehensive HEW reform and simplification. There are other functions in the Department which will remain, albeit in somewhat new forms, once reform and simplification comes into being. These functions include: planning, advocacy, data collection and classification, evaluation and regulation. This paper briefly discusses each of these functions and their associated programs so that one has a complete picture of what happens to all HEW programs and functions under the proposal for reform and simplification.

A. Planning

Currently this Department requires that States or institutions, as a condition of receipt of Federal funds, develop plans for use of these funds. DHEW also provides funds to stimulate planning, for example, programs such as strengthening State Departments of Education, Aging, etc. Several hundred million dollars of Federal funds are used for planning activities such as these.

Our new strategy provides resources to State and local governments with a minimum of Federal restrictions. However, many States do not now have a capacity to plan comprehensively for human resource activities; others that do have such a capacity at the State level do not have it at sub-State levels. Thus strengthening of the planning capacity of State and local governments' planning continues to be a requirement.

Current DHEW programs designed to strengthen planning are shown in Table XI below.

Table XI

Current DHEW Planning Programs  
and FY 74 Funding Levels (millions)

Program Planning

|                               |      |
|-------------------------------|------|
| Emergency Health              | \$ 9 |
| Aging Planning and Operations | 12   |

Comprehensive Planning

|                                                            |       |
|------------------------------------------------------------|-------|
| Strengthening State Departments of Education <sup>a/</sup> | 48    |
| Comprehensive Health Planning                              | 59    |
|                                                            | \$128 |

<sup>a/</sup> Revenue shared



In addition to these programs, there are several special planning programs designed to put in place a network of sub-national planning mechanisms, e.g., comprehensive Health Planning. These were addressed in the Market and Services Development section of the Capacity Building paper.

#### **Program Planning**

The Department's greatest emphasis now is on program planning, principally because that is the interest of our program managers. Many of the Department's current programs require that States or other institutions develop plans for use of program funds. These plans serve two purposes: (1) stimulation of planning; and (2) improvement of Federal monitoring.

In theory, requiring plans improves the effectiveness of DHEW resources. In practice, however, requirements for plans have become merely perfunctory arrangements in the procurement of DHEW resources by the States. Additionally, the highly categorical nature of the plans probably is counter-productive to good planning--100 mini-plans do not add up to a comprehensive plan, and their development diverts resources that might otherwise be used to develop such a plan.

This situation has evolved in part because DHEW does not effectively influence the local planning process. In most instances, the Department is powerless to reject plans, unless they contain glaring procedural errors, because doing so would seriously disrupt local government. Even granting a willingness on the part of DHEW to act, a lack of substantive knowledge and available manpower denies DHEW the influence necessary to adequately review plans and monitor implementation. In short, the concept that Federal program planning requirements, as they exist today, significantly affects the incentives and abilities of States to plan is fallacious.

Accordingly, we believe DHEW should significantly decrease requirements for plans in capacity building programs. With the larger authorities, we see the need for few if any plans per se. Further, we see no requirement for any separate monies to stimulate programmatic planning; the States must and will do this regardless.

### Comprehensive Planning

Stimulating comprehensive planning is a more valid Federal role especially in light of our capacity building initiatives. There is considerable evidence that many State and local governments do not plan effectively. Special revenue sharing makes these deficiencies more significant, adding to the numerous reasons for improving State and local planning capabilities.

In many cases the mere addition of more Federal funds with less constraints will stimulate better planning at State and local levels. But we believe more is needed. We propose the following multi-faceted approach --

- Special revenue sharing authorities require that States develop a comprehensive planning process (and plans) for the use of the funds, and that this process include linkages to local governments.
- Direct technical assistance is to be provided to States in the form of diagnostic field teams to work on-site at the request of States. For example, teams are to be able to conduct an extensive review of the organization, staffing planning and evaluation systems, budgeting process, etc., drawn on experiences in other States to identify successful approaches.
- Financial assistance and incentives for improving planning are to be provided through market and service development activities, principally the Allied Services Act.

### B. Advocacy

There are a number of groups (e.g., the handicapped) that Federally run categorical programs now serve. Many of these programs are to be revenue shared or eliminated with increased financial assistance to individuals. Although there remain protective devices such as regulations and "strings" in special revenue sharing, we propose the added safeguard of advocacy--protecting the interests of certain special groups by "raising a fuss" in their behalf. We propose to adopt a specific advocacy role for five major special groups:

- handicapped/disabled
- aged
- disadvantaged children and youth
- minorities and woman
- poor/welfare recipients and migrants.

Advocacy for these groups is to consist principally of coordination and communication among Federal agencies and among these agencies and States and localities to assure that effective services are delivered to the groups. Internal DHEW special offices for each group are to pick up and oversee certain functions left over when Federal management of programs targeted on the groups is phased out. These functions include:

- collecting and disseminating information on needs, preferences and problems of the target group;
- helping monitor and evaluate State and local activities to ensure that effective services are being delivered to the constituent populations;
- providing a communication link to and from members of the target group, specifically providing information about availability of human services and obtaining information about needs and service delivery;
- coordinating Departmental or government-wide activities for the target group.

C. Evaluation and Data Systems

The Federal leadership role in human resources development through capacity building requires that this Department maintain a significant diagnostic function: determining what human problems are, what currently is being done to resolve them, and what gaps exist. Such information drives research and planning, is essential for regulations, and can shape the nature of Federal assistance.

There are two principal mechanisms for performing the diagnostic role: data systems and evaluation. Through the first, we presently collect three major categories of information:

- Program management information including output and distributive data such as the number of grants administered, monies dispensed, persons served, etc.
- program effectiveness and impact data.
- general statistical data in the health, education, social services and income maintenance areas.

As we reduce program operations, we propose to place even greater emphasis on collecting the latter two categories of information. At the same time, we must continue to collect management data that will allow us to determine where the human resource funds are going--from what and to whom. Such data are important to us both in the diagnostic role and to our regulatory activities designed to assure accountability and responsibility.

As part of special revenue sharing States will be required to provide specific types of management data, jointly agreed upon. But we cannot count upon State produced effectiveness and situational data to be adequate. Rather, we must obtain data by a variety of means, for example: (1) conducting separate evaluations and surveys; (2) using those of other institutions (e.g., Census, Commerce).

We propose to help State and local governments build combined and comprehensive data systems through market and services development and technical assistance. Clearly, development of integrated data systems, with each level of government obtaining information it needs, is both expensive and time consuming. But a myriad of separate data systems, each with their own bits and pieces of information, is more so. Comparability of data is desirable both between States, within and across various human resources functional areas, and among the various Federal departments.

Finally, to achieve a "critical mass" of timely and useful data, we propose to sharpen and focus our evaluation efforts and resources on a few vital activities (particularly those where we have earmarked Federal funds for a particular service or target group.) We propose to do this by improving evaluation planning and targeting our evaluation and audit resources on studies of the effectiveness of our initiatives once they are in place, or prior to that, on potential problems or major uncertainties inherent in the proposals.

#### D. Regulation

It is clear that as we move to convert categorical programs to financial assistance greater reliance will be placed upon private and sub-national government decision making; we must consider the extent to which those non-Federal decision making processes must be controlled to assure that critical Federal objectives are met.

We recognize also that as the Department places greater reliance upon private and sub-national decision making, there will be pressures for expanded Federal control activity from special interest groups, the Congress and the Federal bureaucracy. They will ask such questions as: without categorical programs, how can national priorities be asserted? How can Federal dollars be accounted for? How can DHEW get through a layered bureaucracy and hold State and local officials' "feet to the fire"?

A portion of the Department's activities now fall under the category of regulation, either as direct regulatory activities such as those of FDA, CDC, etc, or (2) regulation as a condition of acceptance of Federal funds. We propose to continue to strengthen the former category of regulatory activities. We also propose, primarily because of special revenue sharing, to make some significant changes in the second category.

We believe that decentralization of decision-making to State and local governments requires that the Department develop effective ways to control a limited number of essential activities, without imposing a vast regulatory structure that contravenes flexibility and simplicity inherent in HEW reform. We see three general objectives for regulatory activity. These are to:

- assure that opportunities for goals and services are generally available to all equally
- protect racial and ethnic minorities and Special concern groups
- assure that institutions are responsive, responsible and accountable.

Because regulation by itself is not a particularly effective means to influence behavior or produce change, we have attempted to weave mechanisms for achieving these objectives throughout the various HEW reform proposals. For example, there are certain earmarks and strings in the special revenue sharing proposals; market and service development and special manpower ~~proposals contain special~~ devices to help minorities. We summarize here some of the regulatory activities discussed in a substantive context elsewhere.

### Procedural Changes

First, there are a number of improvements and changes we propose to make in our regulatory practices. The most important are:

- Greater use of civil suits by the Federal Government, with equitable relief.
- Authorization of civil suits by private parties.
- Deemphasizing use of administrative proceedings as a regulatory mechanism, and Federal fund cut-off as a sanction.
- Use of graduated penalties for non-compliance.
- Greater use of non-coercive mechanisms such as influence (demonstration, provision of model State legislation and regulation, negotiation and technical assistance) and publicity (both public education and public disclosure of evaluation, monitoring and audit results).
- Requirements for intra-state "comparability" of funding for certain services.
- Use of citizen's groups to augment monitoring and to initiate enforcement proceedings.
- Requirements for sub-national governments and institutions to keep records and reports on (1) how Federal funds are used (2) distribution of these funds down to the final beneficiary and (3) changes in individual or group performance or status accruing from use of Federal funds.
- Requirements for States to establish their own monitoring and regulatory mechanisms.
- Requirements for States to set up open and participatory planning processes for Federal allocation of special revenue and other funds.

#### Target Group Activities

The foregoing are all general regulatory mechanisms. In addition, we propose some special regulatory activity for certain groups that now enjoy categorical Federal programs, or which are of special Federal concern.

First, we have built special requirements into the revenue sharing packages that will continue to target services on certain groups--the poor, the handicapped, minority groups.

Second, advocacy offices will have communications links to groups and to sub-national governments and institutions.

Third, equality of access and prohibition of discrimination in general will continue to be mandated through Federal statute (e.g., Title VI of the Civil Rights Act) reinforced by specific anti-discrimination requirements in the various special revenue sharing packages.

Fourth, there are a number of positive mechanisms in HEW reform proposals designed to help special groups and the poor, for example --student assistance, health insurance, income maintenance, special manpower programs, and some special programs in market and service development.

Finally, the focus of the HEW regulatory activity (other than those of FDA, CDC, etc., which continue to look at consumer health and safety) will be on protection of the poor and special groups. With the elimination of a large number of categorical programs, evaluation and audit resources can be focused on the most critical activities affecting the poor, e.g., education for the disadvantaged.



#### E. Federal Services

The basic thrust of HEW reform is to use broad-gauged functional programs to fulfill HEW responsibilities. Most of our existing programs have been discussed within the context of components of this overall scheme. There remain a limited number of programs that simply have not fallen into place elsewhere.

At any given point in time, we can be assured that some public demand will arise that justifiably requires immediate HEW action, but does not lend itself to resolution through one of our broad-gauged policy instruments. Where these demands cannot be met by State and local governments because of lack of funds, or by Federal capacity building, a Federal service subsidy may be required. When these demands become a national priority that we believe should be met, and would not be met at the level we want, then that Federal subsidy for services becomes a reality.

Most such subsidies would be transitory; however, Federal support for some will last longer than others. Regardless, we would hope to work out of the service subsidy business over time.

Programs now in the Federal Services Category are shown in the table on the next page.

Table II

Federal ServicesPrograms Which May Be Phased Out, But Will be Retained for NowFY 74 Funding (millions)

|                                |       |
|--------------------------------|-------|
| Indian Health                  | \$189 |
| Rehabilitation of Drug Abusers | 14    |
| Special Institutions           | 114   |

Programs Which Will Be Radically Changed or Phased-Out

|                                           |     |
|-------------------------------------------|-----|
| St. Elizabeth's Hospital                  | 38  |
| Health Service Grants <u>a/</u>           |     |
| Maternal and Child Health                 | 180 |
| Family Planning                           | 123 |
| Comprehensive Health Services             | 92  |
| Community Mental Health Centers Staffing  | 119 |
| Mental Health of Children                 | 10  |
| Migrant Health                            | 19  |
| Emergency School Assistance <u>b/</u>     | 811 |
| Higher Education Institutional Assistance | 138 |
| Aging Nutrition Programs <u>c/</u>        | 100 |
| Assistance to Refugees <u>d/</u>          | 94  |

a/ Only service subsidies are shown. These are to be phased out in FY 76 when Maximum Liability Insurance exists.

b/ To expire at the end of FY 74.

c/ To be picked up by Income Assistance.

d/ To be picked up in FY 76 by (1) Income Assistance, (2) Health Insurance, (3) Student Assistance and (4) Special Revenue Sharing.

We expect the first group of programs shown in the table to remain a Federal responsibility for the near future, because we do not have readily available instruments to replace them.

Currently, Indians face a complex set of problems. Health, Education and social services are necessary, but residence on reservations and the concentration of the Indian population in a limited number of States both undercut the effectiveness of special revenue sharing. Market development programs have long term implications for the Indian population but cannot meet their immediate needs and may never be adequate because of the compounding of economic and social problems that generates these needs.

Under the Narcotic Addict Rehabilitation Act, there is a commitment to provide treatment to any addict who volunteers for rehabilitation. Since we have, in effect, guaranteed treatment to these individuals, we really cannot rely on providing financial incentives to private and local institutions to supply the required services. Therefore, we propose to maintain the Rehabilitation of Drug Abusers program until such time as it is feasible to reconsider the Narcotic Addict Rehabilitation Act.

The Special Institutions are a set of five basically educational organizations that are supported, through quirks of history and legislation, directly through the HEW budget, rather than indirectly through the grant-in-aid process. They are--

- American Printing House for the Blind (APHB) which produces educational materials and apparatus for blind children. Each State school system is given credit at APHB for its share of the appropriation, based on the number of blind children in the State.
- National Technical Institute for the Deaf which provides a residential facility for post-secondary technical education for deaf persons, and conducts applied research in aspects of deafness related to education and employment.
- Model Secondary School for the Deaf which provides an exemplary secondary education program for deaf persons.
- Gallaudet College, a private non-profit educational institution which provides an undergraduate higher education program for the deaf and a graduate school in the field of deafness.
- Howard University.

For years, our budgetary relationships with the special institutions have lacked a contemporary policy rationale. Annually we negotiate their line item budgets on incrementalist principles, and then act in an amicus curiae role before Congress. Their budgets and operations are thus isolated from policy analysis and the mainstream of our programmatic allocations.

The vagaries of this process are frequently not helpful to the institutions themselves. First of all, they compete for funds in an inappropriate arena, one where there are no comparable institutions/programs against which to judge them. Consequently they are subject to frequent and erratic increases and decreases, which makes intelligent fiscal planning difficult or impossible. In addition, when HEW funds are held up until late in the fiscal year, as frequently happens, they suffer unnecessarily.

We propose to find ways to end our special relationship with these institutions, but we see no quick way this can be done. Thus, for at least the next several years, support will continue. We do propose, however, to drop them as special lines in the HEW budget in favor of a general subsidy, and to phase out their support over a ten year period.

The programs in the second portion of the table are specifically designated to phase out when instruments designed to replace them come into being. It is not an all inclusive list. For many of these programs we propose only to meet prior year obligations. For others, such as the health service grants, we propose to retain service subsidies until health insurance, student assistance or income maintenance can pick up service costs.

November 22, 1972

FUNCTIONAL CLASSIFICATION OF NEW PROGRAMS

| Program                                                 | Financial Assistance for Individuals | Special Revenue Sharing | National Capacity Building | Regulation | Direct Provision of Services | Eliminate |
|---------------------------------------------------------|--------------------------------------|-------------------------|----------------------------|------------|------------------------------|-----------|
| <b>FOOD AND DRUG ADMINISTRATION</b>                     |                                      |                         |                            |            |                              |           |
| <b>Food, drug, and product safety</b>                   |                                      |                         |                            |            |                              |           |
| 1. Foods.....                                           |                                      |                         |                            | X          |                              |           |
| 2. Drugs and devices.....                               |                                      |                         |                            | X          |                              |           |
| 3. Product safety.....                                  |                                      |                         |                            | X          |                              |           |
| 4. Biologics standards.....                             |                                      |                         |                            | X          |                              |           |
| <b>HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION</b> |                                      |                         |                            |            |                              |           |
| <b>Mental Health</b>                                    |                                      |                         |                            |            |                              |           |
| 1. General mental health:                               |                                      |                         |                            |            |                              |           |
| (a) Research.....                                       |                                      |                         |                            |            |                              |           |
| (b) Community mental health centers:                    |                                      |                         |                            |            |                              |           |
| (1) Construction grants.....                            |                                      |                         |                            |            |                              | X         |
| (2) Construction loan guarantees.....                   |                                      |                         |                            |            |                              | MSD       |
| (3) Staffing.....                                       |                                      |                         |                            |            |                              | MSD       |
| (4) Mental health of children.....                      |                                      |                         |                            |            |                              | MSD       |
| 2. Drug abuse:                                          |                                      |                         |                            |            |                              |           |
| (a) Research:                                           |                                      |                         |                            |            |                              |           |
| (1) Project grants.....                                 |                                      |                         |                            |            |                              | RD        |
| (2) Addiction research center.....                      |                                      |                         |                            |            |                              | RD        |
| (b) Community programs:                                 |                                      |                         |                            |            |                              |           |
| (1) Project grants and contracts.....                   |                                      | X                       |                            |            |                              | MSD       |
| (2) Grants to States.....                               |                                      | X                       |                            |            |                              |           |
| (3) Lexington Hospital.....                             |                                      |                         |                            |            |                              | X         |
| (4) Narcotic Addict Rehabilitation Act.....             |                                      |                         |                            |            |                              | X         |

Key for capacity building

RD - Research and development; MSD - Market and service development;  
M - Specialized manpower development; D - Data systems and statistics

## FUNCTIONAL CLASSIFICATION OF NEW PROGRAMS

| Program                                                                 | Financial Assistance for Individuals | Special Revenue Sharing | National Capacity Building | Regulation of Services | Eliminate        |
|-------------------------------------------------------------------------|--------------------------------------|-------------------------|----------------------------|------------------------|------------------|
| <u>HEALTH SERVICES AND MEDICAL HEALTH ADMINISTRATION (CONT)</u>         |                                      |                         |                            |                        |                  |
| 3. Alcoholism:                                                          |                                      |                         |                            |                        |                  |
| (a) Research.....                                                       |                                      |                         | RD                         |                        |                  |
| (b) Community programs:                                                 |                                      |                         |                            |                        |                  |
| (1) Project grants.....                                                 |                                      | X                       | MSD                        |                        |                  |
| (2) Grants to States.....                                               |                                      | X                       |                            |                        |                  |
| 4. Manpower development:                                                |                                      |                         |                            |                        |                  |
| (a) Service-related.....                                                |                                      |                         | Y                          |                        |                  |
| (b) Research-related.....                                               |                                      |                         | Y                          |                        |                  |
| St. Elizabeth Hospital.....                                             |                                      |                         |                            |                        | Transfer to D.C. |
| <u>Health services planning and development</u>                         |                                      |                         |                            |                        |                  |
| 1. Health services research and development:                            |                                      |                         |                            |                        |                  |
| (a) Research grants and contracts.....                                  |                                      |                         | RD                         |                        |                  |
| (b) Emergency medical services and other technology demonstrations..... |                                      |                         |                            |                        |                  |
| (c) Short-term training.....                                            |                                      |                         | MSD                        |                        |                  |
| 2. Comprehensive health planning:                                       |                                      |                         |                            |                        |                  |
| (a) State "a" agencies.....                                             |                                      |                         | MSD                        |                        |                  |
| (b) Areawide "b" agencies.....                                          |                                      |                         | MSD                        |                        |                  |
| (c) Training.....                                                       |                                      |                         | MSD                        |                        |                  |
| (d) Studies and demonstration.....                                      |                                      |                         | MSD                        |                        |                  |
| 3. Regional medical programs.....                                       |                                      |                         | MSD                        |                        |                  |
| 4. Health maintenance organizations.....                                |                                      |                         | MSD                        |                        |                  |
| 5. Medical facilities construction:                                     |                                      |                         |                            |                        |                  |
| (a) Construction grants.....                                            |                                      |                         |                            |                        | X                |
| (b) Interest subsidies.....                                             |                                      |                         |                            |                        | X                |
| (c) Loan guarantees.....                                                |                                      |                         | MSD                        |                        |                  |

Key for capacity building

RD - Research and development; MSD - Market and services development;  
 Y - Specialized manpower development; D - Data systems and statistics

FUNCTIONAL CLASSIFICATION OF NEW PROGRAMS

| Program                                                                                                                                    | Financial Assistance for Individuals | Special Revenue Sharing | National Capacity Building | Regulation of Services | Direct Provision of Services | Eliminate                                          |
|--------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|-------------------------|----------------------------|------------------------|------------------------------|----------------------------------------------------|
| <u>HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION (CONT)</u>                                                                             |                                      |                         |                            |                        |                              |                                                    |
| <u>Health services delivery</u>                                                                                                            |                                      |                         |                            |                        |                              |                                                    |
| 1. Comprehensive health services:                                                                                                          |                                      |                         |                            |                        |                              |                                                    |
| (a) Grants to States.....                                                                                                                  |                                      |                         |                            |                        |                              | X                                                  |
| (b) Family and neighborhood health centers.....                                                                                            | X                                    |                         |                            |                        |                              | MSD                                                |
| (c) Migrant health grants.....                                                                                                             | X                                    |                         |                            |                        |                              | MSD                                                |
| 2. Maternal and child health:                                                                                                              |                                      |                         |                            |                        |                              |                                                    |
| (a) Grants to States.....                                                                                                                  | X                                    |                         |                            |                        |                              |                                                    |
| (b) Health centers                                                                                                                         |                                      |                         |                            |                        |                              |                                                    |
| (1) Maternity and infant care.....                                                                                                         | X                                    |                         |                            |                        |                              | MSD                                                |
| (11) Children and youth.....                                                                                                               | X                                    |                         |                            |                        |                              | MSD                                                |
| (111) Dental health.....                                                                                                                   | X                                    |                         |                            |                        |                              | MSD                                                |
| (c) Research.....                                                                                                                          |                                      |                         |                            |                        |                              | X                                                  |
| (d) Training.....                                                                                                                          | X                                    |                         |                            |                        |                              | MSD                                                |
| 3. Family planning services.....                                                                                                           | X                                    |                         |                            |                        |                              |                                                    |
| 4. National Health Service Corps.....                                                                                                      | X                                    |                         |                            |                        |                              | N                                                  |
| 5. PHS hospitals.....                                                                                                                      | X                                    |                         |                            |                        |                              |                                                    |
| 6. Coast Guard medical services.....                                                                                                       |                                      |                         |                            |                        |                              | Repeal special health benefits for merchant seamen |
| 7. Payment to Hawaii.....                                                                                                                  | X                                    |                         |                            |                        |                              | Transfer to Coast Guard Budget                     |
| <u>Preventive health services</u>                                                                                                          |                                      |                         |                            |                        |                              |                                                    |
| 1. Disease control:                                                                                                                        |                                      |                         |                            |                        |                              |                                                    |
| (a) Infectious diseases:                                                                                                                   |                                      |                         |                            |                        |                              |                                                    |
| (1) Research investigations.....                                                                                                           |                                      |                         |                            |                        |                              | RD                                                 |
| (2) Project grants.....                                                                                                                    |                                      |                         |                            |                        |                              | X                                                  |
| <u>Key for capacity building</u>                                                                                                           |                                      |                         |                            |                        |                              |                                                    |
| RD - Research and development; MSN - Market and service development; N - Specialized manpower development; D - Data systems and statistics |                                      |                         |                            |                        |                              |                                                    |



## FUNCTIONAL CLASSIFICATION OF NEW PROGRAMS

| Program                                                            | Financial Assistance for Individuals | Special Revenue Sharing | National Capacity Building | Regulation | Direct Provision of Services | Eliminate       |
|--------------------------------------------------------------------|--------------------------------------|-------------------------|----------------------------|------------|------------------------------|-----------------|
| Preventive health services (cont)                                  |                                      |                         |                            |            |                              |                 |
| (b) Epidemiology.....                                              |                                      | X                       | D                          |            |                              |                 |
| (c) Smoking and health.....                                        |                                      |                         | D                          |            |                              |                 |
| (d) Laboratory improvement.....                                    |                                      |                         |                            |            |                              | X               |
| 2. Community environmental management:                             |                                      |                         |                            |            |                              |                 |
| (a) Rodent control.....                                            |                                      | X                       |                            |            |                              |                 |
| (b) Lead-based paint.....                                          |                                      | X                       |                            |            |                              |                 |
| (c) Arctic health research center, Southwest                       |                                      |                         |                            |            |                              |                 |
| Appalachian center.....                                            |                                      |                         | MD                         |            |                              |                 |
| (d) Injury control.....                                            |                                      |                         | X                          |            |                              |                 |
| (e) WEDS.....                                                      |                                      |                         | MSD                        |            |                              |                 |
| 3. Occupational health: 1/                                         |                                      |                         |                            |            |                              |                 |
| (a) Research grants.....                                           |                                      |                         |                            |            | X                            |                 |
| (b) Standards development.....                                     |                                      |                         |                            |            | X                            |                 |
| (c) Technical assistance.....                                      |                                      |                         |                            |            | X                            |                 |
| (d) Training.....                                                  |                                      |                         | M                          |            |                              |                 |
| National health statistics.....                                    |                                      |                         | D                          |            |                              |                 |
| Retirement pay and medical benefits for commissioned officers..... | X                                    |                         |                            |            |                              |                 |
| Indian health services.....                                        | X                                    |                         |                            |            | X                            |                 |
| Emergency health:                                                  |                                      |                         |                            |            |                              |                 |
| (a) Medical stockpiles.....                                        |                                      |                         |                            |            |                              | X               |
| (b) Community preparedness.....                                    |                                      |                         |                            |            |                              | Transfer to OEP |
| 1/ To be transferred to Department of Economic Development         |                                      |                         |                            |            |                              |                 |

## Key for capacity building

Ry - Research and development; MSD - Market and service development;  
 M - Specialized manpower development; D - Data systems and statistics

FUNCTIONAL CLASSIFICATION OF NEW PROGRAMS

5

| Program                                        | Financial Assistance for Individuals | Special Revenue Sharing | National Capacity Building | Regulation of Services | Direct Provision | Eliminate |
|------------------------------------------------|--------------------------------------|-------------------------|----------------------------|------------------------|------------------|-----------|
| <b>NATIONAL INSTITUTES OF HEALTH</b>           |                                      |                         |                            |                        |                  |           |
| Research Institutes (analysis by program)      |                                      |                         |                            |                        |                  |           |
| 1. Research grants:                            |                                      |                         |                            |                        |                  |           |
| (a) Regular program.....                       |                                      |                         | RD                         |                        |                  |           |
| (b) General research support grants.....       |                                      |                         | RD                         |                        |                  |           |
| (c) Multidisciplinary centers.....             |                                      |                         | RD                         |                        |                  |           |
| (d) Special program.....                       |                                      |                         | RD                         |                        |                  |           |
| 2. Research training programs.....             |                                      |                         | RD                         |                        |                  |           |
| 3. Intramural research.....                    |                                      |                         | RD                         |                        |                  |           |
| 4. Collaborative research and development..... |                                      |                         | RD                         |                        |                  |           |
| <b>Health Manpower</b>                         |                                      |                         |                            |                        |                  |           |
| 1. Health Professionals:                       |                                      |                         |                            |                        |                  |           |
| (a) Institutional assistance:                  |                                      |                         |                            |                        |                  |           |
| (1) Capitation grants.....                     |                                      |                         | N                          |                        |                  |           |
| (2) Start-up and conversion assistance.....    |                                      |                         |                            |                        |                  |           |
| (3) Financial distress grants.....             |                                      |                         |                            |                        |                  |           |
| (4) Special projects.....                      |                                      |                         |                            |                        |                  |           |
| (5) Family practice of medicine.....           |                                      |                         |                            |                        |                  |           |
| (6) Teacher training.....                      |                                      |                         |                            |                        |                  |           |
| (b) Student assistance:                        |                                      |                         |                            |                        |                  |           |
| (1) Student loans.....                         |                                      |                         |                            |                        |                  |           |
| (2) Scholarships.....                          |                                      |                         |                            |                        |                  |           |
| (c) Construction assistance:                   |                                      |                         |                            |                        |                  |           |
| (1) Grants.....                                |                                      |                         |                            |                        |                  |           |
| (2) Interest subsidies.....                    |                                      |                         |                            |                        |                  |           |
| (3) Loan guarantees.....                       |                                      |                         |                            |                        |                  |           |

Key for capacity building

RD - Research and development; MSD - Market and service development;  
N - Specialized manpower development; D - Data systems and statistics

# FUNCTIONAL CLASSIFICATION OF NEW PROGRAMS

6

| Program                                          | Financial Assistance for Individuals | Special Revenue Sharing | National Capacity Building | Regulation | Direct Provision of Services | Eliminate |
|--------------------------------------------------|--------------------------------------|-------------------------|----------------------------|------------|------------------------------|-----------|
| <b>NATIONAL INSTITUTES OF HEALTH (CONT)</b>      |                                      |                         |                            |            |                              |           |
| <b>2. Nursing:</b>                               |                                      |                         |                            |            |                              |           |
| <b>(a) Institutional assistance:</b>             |                                      |                         |                            |            |                              |           |
| (1) Capital grants.....                          |                                      |                         | M                          |            |                              |           |
| (2) Start-up assistance.....                     |                                      |                         | M                          |            |                              |           |
| (3) Financial distress grants.....               |                                      |                         |                            |            |                              | X         |
| (4) Social projects and demonstrations.....      |                                      |                         | M                          |            |                              |           |
| <b>(b) Student assistance:</b>                   |                                      |                         |                            |            |                              |           |
| (1) Student loans.....                           |                                      |                         | M                          |            |                              |           |
| (2) Scholarships.....                            |                                      |                         | M                          |            |                              |           |
| (3) Professional traineeships.....               |                                      |                         | M                          |            |                              |           |
| <b>(c) Construction assistance:</b>              |                                      |                         |                            |            |                              |           |
| (1) Grants.....                                  |                                      |                         |                            |            |                              | X         |
| (2) Interest subsidies.....                      |                                      |                         |                            |            |                              | X         |
| (3) Loan guarantees.....                         |                                      |                         | MSD                        |            |                              |           |
| <b>3. Public Health:</b>                         |                                      |                         |                            |            |                              |           |
| (a) Institutional assistance.....                |                                      |                         | M                          |            |                              |           |
| (b) Student assistance.....                      |                                      |                         | M                          |            |                              |           |
| (c) Special projects and demonstrations.....     |                                      |                         | N                          |            |                              |           |
| <b>4. Allied Health:</b>                         |                                      |                         |                            |            |                              |           |
| (a) Institutional assistance.....                |                                      |                         | M                          |            |                              |           |
| (b) Student Assistance.....                      |                                      |                         | M                          |            |                              |           |
| (c) Special projects and demonstrations.....     |                                      |                         | M                          |            |                              |           |
| <b>5. Special education initiative programs:</b> |                                      |                         |                            |            |                              |           |
| (a) Educational initiative awards.....           |                                      |                         | M                          |            |                              |           |
| (b) Computer technology.....                     |                                      |                         | M                          |            |                              |           |
| National Library of Medicine.....                |                                      |                         | D                          |            |                              |           |
| Scientific Activities Overseas.....              |                                      |                         |                            |            |                              | RD        |
| (Special foreign currency program)               |                                      |                         |                            |            |                              |           |

## Key for capacity building

RD - Research and development - MSD - Market and service development;  
 M - Specialized manpower development; D - Data systems and statistics

FUNCTIONAL CLASSIFICATION OF NEW PROGRAMS

7

| Program                                                     | Financial Assistance for Individuals | Special Revenue Sharing | National Capacity Building | Regulation | Direct Provision of Services | Eliminate |
|-------------------------------------------------------------|--------------------------------------|-------------------------|----------------------------|------------|------------------------------|-----------|
| <b>OFFICE OF EDUCATION</b>                                  |                                      |                         |                            |            |                              |           |
| <b>Elementary and Secondary Education:</b>                  |                                      |                         |                            |            |                              |           |
| 1. Educationally deprived children (ESEA I).....            |                                      |                         |                            |            |                              | X         |
| 2. Supplementary services (ESEA III):                       |                                      |                         |                            |            |                              |           |
| (a) State plan program.....                                 |                                      |                         |                            |            |                              | X         |
| (b) Special projects.....                                   |                                      |                         |                            |            |                              | X         |
| 3. Strengthening State departments of education (ESEA V):   |                                      |                         |                            |            |                              |           |
| (a) Grants to States (Part A).....                          |                                      |                         |                            |            |                              | X         |
| (b) Grants for special projects (Part A).....               |                                      |                         |                            |            |                              | X         |
| (c) Comprehensive planning and evaluation (Part C).....     |                                      |                         |                            |            |                              | X         |
| 4. Bilingual education (ESEA VII).....                      |                                      |                         |                            |            |                              | MSD       |
| 5. Follow-through (EOA, Sec. 222).....                      |                                      |                         |                            |            |                              |           |
| (a) (2).....                                                |                                      |                         |                            |            |                              |           |
| 6. Special projects for Indian education (EHA, Part d)..... |                                      |                         |                            |            |                              | MSD       |
| 7. LRA grants for Indian education.....                     |                                      |                         |                            |            |                              | X         |
| <b>Education for the handicapped:</b>                       |                                      |                         |                            |            |                              |           |
| 1. State grant program (EHA Part B).....                    |                                      |                         |                            |            |                              | X         |
| 2. Special target programs:                                 |                                      |                         |                            |            |                              |           |
| (a) Deaf-blind centers.....                                 |                                      |                         |                            |            |                              | MSD       |
| (b) Early childhood projects (EHA Part C, Sec. 622).....    |                                      |                         |                            |            |                              | MSD       |
| (c) Special learning disabilities (EHA Part C).....         |                                      |                         |                            |            |                              | MSD       |
| (d) Regional resource centers (EHA Part C, Sec. 621).....   |                                      |                         |                            |            |                              | MSD       |

**Key for capacity building**

ED - Research and development; MSD - Market and service development;  
 N - Specialized manpower development; D - Data systems and statistics

# FUNCTIONAL CLASSIFICATION OF NEW PROGRAMS

8

| Program                                                                           | Financial Assistance for Individuals | Special Revenue Sharing | National Capacity Building | Regulation | Direct Provision of Services | Eliminate                                |
|-----------------------------------------------------------------------------------|--------------------------------------|-------------------------|----------------------------|------------|------------------------------|------------------------------------------|
| <u>Education for the Handicapped (cont)</u>                                       |                                      |                         |                            |            |                              |                                          |
| 3. Innovation and development (EHA Part E, Sec. 641 & 642).....                   |                                      |                         | MSD                        |            |                              |                                          |
| 4. Technology and communication:                                                  |                                      |                         |                            |            |                              |                                          |
| (a) Media services and captioned films (EHA Part F).....                          |                                      |                         | MSD                        |            |                              |                                          |
| (b) Recruitment and information (EHA Part D, Sec. 633).....                       |                                      |                         | MSD                        |            |                              |                                          |
| 5. Special education and manpower development (EHA Part D, Sec. 631 and 632)..... |                                      |                         |                            |            |                              |                                          |
| <u>School assistance in Federally affected areas:</u>                             |                                      |                         |                            |            |                              |                                          |
| 1. Maintenance and operations (P.L. 874):                                         |                                      |                         |                            |            |                              |                                          |
| (a) Payments to local educational agencies.....                                   |                                      |                         |                            |            |                              |                                          |
| (b) Payments to other Federal agencies.....                                       |                                      |                         |                            |            |                              | Transfer to appropriate "Federal agency" |
| 2. Construction (P.L. 815).....                                                   |                                      |                         |                            |            |                              |                                          |
| <u>Emergency School Aid:</u>                                                      |                                      |                         |                            |            |                              |                                          |
| 1. Special projects.....                                                          |                                      |                         |                            |            |                              | Program lasts for 100 years              |
| 2. State apportionment.....                                                       |                                      |                         |                            |            |                              |                                          |
| <u>Equal Education Opportunity Act</u>                                            |                                      |                         |                            |            |                              |                                          |
| State apportionment.....                                                          |                                      |                         |                            |            |                              | X                                        |

## Key for capacity building

MS - research and development; MSD - Market and service development;  
 M - Specialized manpower development; D - Data systems and statistics

FUNCTIONAL CLASSIFICATION OF NEW PROGRAMS

| Program                                                                | Financial Assistance for Individuals | Special Revenue Sharing | National Capacity Building | Regulation | Direct Provision of Services | Eliminate |
|------------------------------------------------------------------------|--------------------------------------|-------------------------|----------------------------|------------|------------------------------|-----------|
| Occupational, vocational and adult education:                          |                                      |                         |                            |            |                              |           |
| 1. Occupational education:                                             |                                      |                         |                            |            |                              |           |
| 2. Grants to States for vocational education:                          |                                      |                         |                            |            |                              |           |
| (a) Basic vocational education programs:                               |                                      |                         |                            |            |                              |           |
| (1) Annual appropriation (VEA Part B).....                             |                                      |                         |                            |            |                              | X         |
| (2) Permanent appropriation (Smith-Hughes Act).....                    |                                      |                         |                            |            |                              | X         |
| (b) Programs for students with special needs (VEA Part B).....         |                                      |                         |                            |            |                              | X         |
| (c) Counselor and homecoming education (VEA Part F).....               |                                      |                         |                            |            |                              | X         |
| (d) Work-study (VEA Part H).....                                       |                                      |                         |                            |            |                              | X         |
| (e) Cooperative education (VEA Part G).....                            |                                      |                         |                            |            |                              | X         |
| (f) State advisory councils (VEA Part A).....                          |                                      |                         |                            |            |                              | X         |
| 3. Vocational research:                                                |                                      |                         |                            |            |                              |           |
| (a) Innovation (VEA Part D).....                                       |                                      |                         |                            |            |                              | X         |
| (b) Curriculum development (VEA Part I).....                           |                                      |                         |                            |            |                              | X         |
| (c) Research-Grants to States (VEA Part C).....                        |                                      |                         |                            |            |                              | X         |
| 4. Career education (CRA).....                                         |                                      |                         |                            |            |                              | MSD       |
| 5. State postsecondary education commissions (NEA XII, Sec. 1202)..... |                                      |                         |                            |            |                              | NSD       |

Key for capacity building

RD - Research and development; NSU - Market and service development;  
 N - Specialized manpower development; D - Data systems and statistics

## FUNCTIONAL CLASSIFICATION OF NEW PROGRAMS

| PROGRAM                                                     | Financial Assistance for Individuals | Special Revenue Sharing | National Capacity Building | Regulation | Direct Provision of Services | Eliminate |
|-------------------------------------------------------------|--------------------------------------|-------------------------|----------------------------|------------|------------------------------|-----------|
| <u>Occupational, vocational, and adult education (cont)</u> |                                      |                         |                            |            |                              |           |
| 6. Adult education:                                         |                                      |                         |                            |            |                              |           |
| (a) Grants to States (Adult Education Act).....             |                                      |                         | X                          |            |                              |           |
| (b) Special projects (Adult Education Act).....             |                                      |                         |                            |            |                              |           |
| (c) Teacher training (Adult Education Act).....             |                                      |                         | NSD                        |            |                              |           |
| (d) Adult education for Indians (TEA).....                  |                                      |                         | M                          |            |                              |           |
| Indians (TEA).....                                          |                                      |                         | NSD                        |            |                              |           |
| <u>Higher Education:</u>                                    |                                      |                         |                            |            |                              |           |
| 1. Student assistance:                                      |                                      |                         |                            |            |                              |           |
| (a) Grants and work-study (HEA-IV):                         |                                      |                         |                            |            |                              |           |
| (1) Basic opportunity grants.....                           | X                                    |                         |                            |            |                              |           |
| (2) Supplementary opportunity grants.....                   |                                      |                         |                            |            |                              | X         |
| (3) Work-study.....                                         | X                                    |                         |                            |            |                              | X         |
| (b) Cooperative education.....                              |                                      |                         |                            |            |                              | X         |
| (c) State scholarships.....                                 | X                                    |                         |                            |            |                              | X         |
| (d) Subsidized loans (HEA IV).....                          |                                      |                         |                            |            |                              | X         |
| (e) Guaranteed loans.....                                   | X                                    |                         |                            |            |                              | X         |
| (f) Direct loans (HEA IV):                                  |                                      |                         |                            |            |                              | X         |
| (1) Federal capital contributions.....                      |                                      |                         |                            |            |                              | X         |
| (2) Loans to institutions.....                              |                                      |                         |                            |            |                              | X         |
| (3) Teacher cancellations.....                              |                                      |                         |                            |            |                              | X         |
| (g) Student loan marketing association.....                 | X                                    |                         |                            |            |                              | X         |

Key for capacity building

RJ - Research and development; NSD - Market and service development;  
 M - Specialized manpower development; D - Data systems and statistics



## FUNCTIONAL CLASSIFICATION OF NEW PROGRAMS

| Program                                                                     | Financial Assistance for Individuals | Special Revenue Sharing | National Capacity Building | Regulation | Direct Provision of Services | Eliminate |
|-----------------------------------------------------------------------------|--------------------------------------|-------------------------|----------------------------|------------|------------------------------|-----------|
| <u>Higher education (cont)</u>                                              |                                      |                         |                            |            |                              |           |
| 2. Special programs for the disadvantaged (HEA-IV):                         |                                      |                         |                            |            |                              |           |
| (a) Talent search.....                                                      |                                      |                         | NSD                        |            |                              |           |
| (b) Special services in college.....                                        |                                      |                         | NSD                        |            |                              |           |
| (c) Upward bound.....                                                       |                                      |                         | NSD                        |            |                              |           |
| 3. Institutional assistance:                                                |                                      |                         |                            |            |                              |           |
| (a) Strengthening developing institutions (HEA-III).....                    |                                      |                         | NSD                        |            |                              |           |
| (b) Construction (HEA-VII):                                                 |                                      |                         |                            |            |                              |           |
| (1) Subsidized loans.....                                                   |                                      |                         |                            |            |                              | X         |
| (2) Grants.....                                                             |                                      |                         |                            |            |                              | X         |
| (3) Loan guarantees.....                                                    |                                      |                         |                            |            |                              |           |
| (c) Language training and area studies (HEA VI and Fulbright-Hays Act)..... |                                      |                         | M                          |            |                              |           |
| (d) University community services (HEA-I).....                              |                                      |                         |                            |            |                              | X         |
| (e) Aid to land-grant colleges:                                             |                                      |                         |                            |            |                              |           |
| (1) Annual appropriation (Bankhead-Jones Act).....                          |                                      |                         |                            |            |                              | X         |
| (2) Permanent appropriation (Second Morrill Act).....                       |                                      |                         |                            |            |                              | X         |
| (f) Postsecondary innovation (GEPA, Sec. 404).....                          |                                      |                         | NSD                        |            |                              |           |
| (g) General institutional assistance (HEA IV).....                          |                                      |                         |                            |            |                              | X         |
| (h) Veterans education subsidy.....                                         |                                      |                         |                            |            |                              | X         |
| 4. College personnel development (HEA-LX):                                  |                                      |                         |                            |            |                              |           |
| (a) College teacher fellowships.....                                        |                                      |                         | M                          |            |                              |           |
| (b) Fellowships for disadvantaged.....                                      |                                      |                         | M                          |            |                              |           |

Key for capacity building

RJ - Research and development; NSD - market and service development;  
M - Specialized manpower development; D - Data systems and statistics

# FUNCTIONAL CLASSIFICATION OF NEW PROGRAMS

12

| Program                                                     | Financial Assistance for Individuals | Special Revenue Sharing | National Capacity Building | Regulation of Services | Direct Provision of Services | Eliminate          |
|-------------------------------------------------------------|--------------------------------------|-------------------------|----------------------------|------------------------|------------------------------|--------------------|
| <b>Library resources:</b>                                   |                                      |                         |                            |                        |                              |                    |
| 1. Public libraries:                                        |                                      |                         |                            |                        |                              |                    |
| (a) Services:                                               |                                      |                         |                            |                        |                              |                    |
| (1) Grants for public libraries (LSCA I).....               |                                      |                         |                            |                        |                              | X                  |
| (2) Interlibrary cooperation (LSCA III).....                |                                      |                         |                            |                        |                              | X                  |
| (c) Construction grants.....                                |                                      |                         | MSD                        |                        |                              | X                  |
| (c) Construction loan guarantees.....                       |                                      |                         |                            |                        |                              | X                  |
| 2. School library resources (NSA II).....                   |                                      | X                       |                            |                        |                              |                    |
| 3. College libraries:                                       |                                      |                         |                            |                        |                              |                    |
| (a) College library resources (NSA II-A).....               |                                      |                         |                            |                        |                              | X                  |
| (b) Librarian training (NSA II-B).....                      |                                      |                         | M                          |                        |                              |                    |
| (c) Library demonstrations (NSA II-S).....                  |                                      |                         | MSD                        |                        |                              |                    |
| 4. Equipment and minor remodeling (NSA II).....             |                                      | X                       |                            |                        |                              |                    |
| 5. Undergraduate instructional equipment (NSA VI).....      |                                      |                         |                            |                        |                              | X                  |
| <b>Educational development:</b>                             |                                      |                         |                            |                        |                              |                    |
| 1. Education professions development:                       |                                      |                         |                            |                        |                              |                    |
| (a) Teacher Corps (EPDA Part B-1).....                      |                                      |                         | MSD                        |                        |                              | Transfer to ACTION |
| (b) State grants (EPDA Part B-2).....                       |                                      | X                       |                            |                        |                              |                    |
| (c) Long-term training (EPDA Part C).....                   |                                      |                         | M                          |                        |                              |                    |
| (d) Elementary and secondary development (EPDA Part D)..... |                                      |                         | MSD                        |                        |                              |                    |

## Key for capacity building

ED - Research and development; MSU - Market and service development;  
M - Specialized manpower development; D - Data systems and statistics

## FUNCTIONAL CLASSIFICATION OF NEW PROGRAMS

| Program                                 | Financial Assistance for Individuals | Special Revenue Sharing | National Capacity Building | Regulation | Direct Provision of Services | Eligible |
|-----------------------------------------|--------------------------------------|-------------------------|----------------------------|------------|------------------------------|----------|
| Educational development: (cont)         |                                      |                         |                            |            |                              |          |
| (e) Vocational education                |                                      |                         |                            |            |                              |          |
| (f) (EPDA Part F).....                  |                                      |                         | NSI                        |            |                              |          |
| (f) New careers in education            |                                      |                         |                            |            |                              |          |
| (Section 504).....                      |                                      |                         | NSI                        |            |                              |          |
| (g) Higher education                    |                                      |                         |                            |            |                              |          |
| (EPDA Part E):                          |                                      |                         | NSF                        |            |                              |          |
| (1) Institutes.....                     |                                      |                         | M                          |            |                              |          |
| (2) Fellowships.....                    |                                      |                         |                            |            |                              |          |
| 2. National priority programs:          |                                      |                         |                            |            |                              |          |
| (a) Educational technology              |                                      |                         |                            |            |                              |          |
| demonstrations.....                     |                                      |                         | MSD                        |            |                              |          |
| (b) Drug abuse education                |                                      |                         |                            |            |                              |          |
| (DME Act).....                          |                                      |                         | MSD                        |            |                              |          |
| (c) Right to read                       |                                      |                         |                            |            |                              |          |
| (Coop. Res. Act).....                   |                                      |                         | MSD                        |            |                              |          |
| (d) Installation of exemplary           |                                      |                         |                            |            |                              |          |
| projects (Coop. Res. Act).....          |                                      |                         | MSD                        |            |                              |          |
| (e) Environmental education             |                                      |                         |                            |            |                              |          |
| (EE Act).....                           |                                      |                         | MSD                        |            |                              |          |
| (f) Nutrition and health                |                                      |                         |                            |            |                              |          |
| (ESA, Sec. 608).....                    |                                      |                         | MSD                        |            |                              |          |
| (g) Dropout prevention (ESEA VIII)..... |                                      |                         | MSD                        |            |                              |          |
| 3. Data systems improvement:            |                                      |                         |                            |            |                              |          |
| (a) Educational statistics:             |                                      |                         |                            |            |                              |          |
| (1) Surveys and special                 |                                      |                         |                            |            |                              |          |
| studies.....                            |                                      |                         |                            |            |                              |          |
| (2) Common core of data.....            |                                      |                         |                            |            |                              |          |
| (b) National achievement study          |                                      |                         |                            |            |                              |          |
| (Coop. Res. Act).....                   |                                      |                         |                            |            |                              |          |

## Key for capacity building

W - Research and development; MSD - Market and service development;  
 M - Specialized manpower development; D - Data systems and statistics

## FUNCTIONAL CLASSIFICATION OF NEW PROGRAMS

| Program                                                                            | Financial Assistance for Individuals | Special Revenue Sharing | National Capacity Building | Regulation of Services | Direct Provision of Services | Eliminate |
|------------------------------------------------------------------------------------|--------------------------------------|-------------------------|----------------------------|------------------------|------------------------------|-----------|
| Educational activities overseas (Special foreign currency program) (P.L. 480)..... |                                      |                         |                            |                        | RD                           |           |
| Student loan insurance fund (NEA IV).....                                          | X                                    |                         |                            |                        |                              |           |
| Higher education facilities loan and insurance fund (NEFA III).....                |                                      |                         |                            |                        |                              | X         |
| Legislative program                                                                |                                      |                         |                            |                        |                              |           |
| 1. Educational renewal.....                                                        |                                      |                         |                            |                        | MSD                          |           |
| 2. Educational revenue sharing (hold harmless).....                                |                                      | X                       |                            |                        |                              |           |
| NATIONAL INSTITUTE OF EDUCATION.....                                               |                                      |                         |                            |                        | RD                           |           |

## Key for capacity building

RD - Research and development; MSD - Market and service development;  
 N - Specialized manpower development; D - Data system and statistics

## FUNCTIONAL CLASSIFICATION OF NEW PROGRAMS

| Program                                            | Financial<br>Assistance for<br>Individuals | Special<br>Revenue<br>Sharing | National<br>Capacity<br>Building | Regulation<br>of Services | Direct<br>Provision<br>of Services | Eliminate |
|----------------------------------------------------|--------------------------------------------|-------------------------------|----------------------------------|---------------------------|------------------------------------|-----------|
| <u>SOCIAL AND REHABILITATION SERVICE</u>           |                                            |                               |                                  |                           |                                    |           |
| <u>Grants to States for public assistance</u>      |                                            |                               |                                  |                           |                                    |           |
| 1. Maintenance assistance.....                     | X                                          |                               |                                  |                           |                                    |           |
| 2. Medical assistance.....                         | X                                          |                               |                                  |                           |                                    |           |
| 3. Social services.....                            |                                            | X                             |                                  |                           |                                    |           |
| 4. Staff training.....                             | X                                          |                               |                                  |                           |                                    |           |
| 5. Child welfare services.....                     |                                            | X                             |                                  |                           |                                    |           |
| <u>Work incentives</u>                             |                                            |                               |                                  |                           |                                    |           |
| 1. Training and incentives.....                    | X                                          |                               |                                  |                           |                                    |           |
| 2. Child care.....                                 | X                                          |                               |                                  |                           |                                    |           |
| <u>Social and Rehabilitation Services</u>          |                                            |                               |                                  |                           |                                    |           |
| <u>1. Rehabilitation services and facilities:</u>  |                                            |                               |                                  |                           |                                    |           |
| (a) Basic State grants.....                        |                                            | X                             |                                  |                           |                                    |           |
| (b) Innovation.....                                |                                            | X                             |                                  |                           |                                    |           |
| (c) Service projects:                              |                                            |                               |                                  |                           |                                    |           |
| (1) Expansion grants.....                          |                                            |                               |                                  |                           |                                    | MSD       |
| (2) Projects with industry.....                    |                                            |                               |                                  |                           |                                    | MSD       |
| (3) New career opportunities.....                  |                                            |                               |                                  |                           |                                    | SD        |
| (4) Rehabilitation facility improvement.....       |                                            |                               |                                  |                           |                                    | MSD       |
| (d) Vocational rehabilitation facilities.....      |                                            |                               |                                  |                           |                                    | SD        |
| <u>2. Grants for the developmentally disabled:</u> |                                            |                               |                                  |                           |                                    |           |
| (a) State grants.....                              |                                            | X                             |                                  |                           |                                    |           |
| (b) Service projects.....                          |                                            |                               |                                  |                           |                                    | MSD       |

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## FUNCTIONAL CLASSIFICATION OF NEW PROGRAMS

| Program                                                                     | Financial Assistance for Individuals | Special Revenue Sharing | National Capacity Building | Regulation | Direct Provision of Services | Eliminate |
|-----------------------------------------------------------------------------|--------------------------------------|-------------------------|----------------------------|------------|------------------------------|-----------|
| <b>Social and Rehabilitation Services (Cont)</b>                            |                                      |                         |                            |            |                              |           |
| <b>(c) University affiliated facilities:</b>                                |                                      |                         |                            |            |                              |           |
| (1) Staffing grants.....                                                    |                                      |                         | RD                         |            |                              |           |
| (2) Construction.....                                                       |                                      |                         |                            |            |                              | X         |
| <b>3. Special programs for the aging:</b>                                   |                                      |                         |                            |            |                              |           |
| (a) Planning and operations.....                                            |                                      | X                       |                            |            |                              |           |
| (b) Area-wide projects.....                                                 |                                      |                         | MSD                        |            |                              |           |
| (c) Community programs.....                                                 |                                      | X                       |                            |            |                              |           |
| (d) Nutrition.....                                                          | X                                    |                         |                            |            |                              |           |
| <b>4. Youth development and delinquency prevention.....</b>                 |                                      |                         |                            |            |                              |           |
|                                                                             |                                      |                         | MSD                        |            |                              |           |
| <b>5. Research:</b>                                                         |                                      |                         |                            |            |                              |           |
| (a) Research and demonstrations.....                                        |                                      |                         | RD                         |            |                              |           |
| (b) Income maintenance projects.....                                        |                                      |                         | RD                         |            |                              |           |
| (c) Special centers:                                                        |                                      |                         |                            |            |                              |           |
| (1) Research centers.....                                                   |                                      |                         | RD                         |            |                              |           |
| (2) National Center for Deaf/Blind.....                                     |                                      |                         | MSD                        |            |                              |           |
| (3) Regional Research Institutes.....                                       |                                      |                         | RD                         |            |                              |           |
| <b>6. Training (rehabilitation, social workers, aging, et. al).....</b>     |                                      |                         |                            |            |                              |           |
|                                                                             |                                      |                         | M                          |            |                              |           |
| <b>Research activities overseas (Special foreign currency program).....</b> |                                      |                         |                            |            |                              |           |
|                                                                             |                                      |                         | RD                         |            |                              |           |
| <b>Assistance to refugees in the U.S.:</b>                                  |                                      |                         |                            |            |                              |           |
| 1. Cash assistance.....                                                     | X                                    |                         |                            |            |                              |           |
| 2. Social services.....                                                     |                                      | X                       |                            |            |                              |           |

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## FUNCTIONAL CLASSIFICATION OF NEW PROGRAMS

| Program                                                       | Financial Assistance for Individuals | Special Revenue Sharing | National Capacity Building | Regulation of Services | Direct Provision of Services | Eliminate |
|---------------------------------------------------------------|--------------------------------------|-------------------------|----------------------------|------------------------|------------------------------|-----------|
| Assistance to refugees in the U.S. (cont)                     |                                      |                         |                            |                        |                              |           |
| 3. Payment to Dade County school systems.....                 |                                      |                         |                            |                        |                              | X         |
| 4. Student loans.....                                         | X                                    |                         |                            |                        |                              |           |
| 5. Health services.....                                       | X                                    |                         |                            |                        |                              |           |
| 6. Transportation and resettlement.....                       |                                      |                         |                            |                        |                              | X         |
| <b>SOCIAL SECURITY ADMINISTRATION</b>                         |                                      |                         |                            |                        |                              |           |
| <b>Payments to Social Security Trust Funds:</b>               |                                      |                         |                            |                        |                              |           |
| 1. Matching payments for supplementary medical insurance..... | X                                    |                         |                            |                        |                              |           |
| 2. Hospital insurance for the uninsured.....                  | X                                    |                         |                            |                        |                              |           |
| 3. Military service credits.....                              | X                                    |                         |                            |                        |                              |           |
| 4. Retirement benefits for certain uninsured persons.....     | X                                    |                         |                            |                        |                              |           |
| Special benefits for disabled coal miners.....                | X                                    |                         |                            |                        |                              |           |
| <b>Trust Funds:</b>                                           |                                      |                         |                            |                        |                              |           |
| 1. Old-age and survivors insurance:                           |                                      |                         |                            |                        |                              |           |
| (a) General income support.....                               | X                                    |                         |                            |                        |                              |           |
| (b) College student aid.....                                  | X                                    |                         |                            |                        |                              |           |
| 2. Disability insurance.....                                  | X                                    |                         |                            |                        |                              |           |
| 3. Health insurance.....                                      | X                                    |                         |                            |                        |                              |           |
| 4. Supplementary medical insurance.....                       | X                                    |                         |                            |                        |                              |           |

**Key for capacity building**

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## FUNCTIONAL CLASSIFICATION OF NEW PROGRAMS

| Program                                        | Financial Assistance for Individuals | Special Revenue Sharing | National Capacity Building | Regulation | Direct Provision of Services | Eliminate |
|------------------------------------------------|--------------------------------------|-------------------------|----------------------------|------------|------------------------------|-----------|
| <u>SPECIAL INSTITUTIONS</u>                    |                                      |                         |                            |            |                              |           |
| American Printing House for the Blind.....     |                                      |                         |                            |            |                              | X         |
| National Technical Institute for the Deaf..... |                                      |                         |                            |            |                              |           |
| Model Secondary School for the Deaf.....       |                                      |                         |                            |            |                              |           |
| Gallaudet College.....                         |                                      |                         |                            |            |                              |           |
| Howard University.....                         |                                      |                         |                            |            |                              |           |

Phase-out over next 5 to 10 years

## OFFICE OF CHILD DEVELOPMENT

|                                            |  |  |  |  |  |     |
|--------------------------------------------|--|--|--|--|--|-----|
| <u>Child Development</u>                   |  |  |  |  |  |     |
| 1. Research.....                           |  |  |  |  |  | RD  |
| 2. Demonstrations.....                     |  |  |  |  |  | MSD |
| 3. Head Start:                             |  |  |  |  |  |     |
| (a) Full-time and summer programs.....     |  |  |  |  |  | X   |
| (b) Experimentation and demonstration..... |  |  |  |  |  | MSD |
| <u>DEPARTMENT-WIDE PROGRAM</u>             |  |  |  |  |  |     |
| Allied services.....                       |  |  |  |  |  | MSD |

## Key for capacity building

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## FUNCTIONAL CLASSIFICATION OF NEW PROGRAMS

| Program                                                                                    | Financial<br>Assistance for<br>Individuals | Special<br>Revenue<br>Sharing | National<br>Capacity<br>Building | Regulation | Direct<br>Provision<br>of Services | Eliminate |
|--------------------------------------------------------------------------------------------|--------------------------------------------|-------------------------------|----------------------------------|------------|------------------------------------|-----------|
| Programs to be transferred to                                                              |                                            |                               |                                  |            |                                    |           |
| Department of Human Resources                                                              |                                            |                               |                                  |            |                                    |           |
| From the Office of Economic Opportunity:                                                   |                                            |                               |                                  |            |                                    |           |
| 1. Alcoholism, family planning,<br>drug rehabilitation, migrants:                          |                                            |                               |                                  |            |                                    |           |
| (a) Service components.....                                                                |                                            | X                             |                                  |            |                                    |           |
| (b) Demonstration components.....                                                          |                                            |                               |                                  |            |                                    | XSD       |
| From the Department of Labor:                                                              |                                            |                               |                                  |            |                                    |           |
| Manpower Administration:                                                                   |                                            |                               |                                  |            |                                    |           |
| 1. Manpower training Services.....                                                         |                                            |                               |                                  |            |                                    | XSD       |
| 2. Emergency employment assistance.....                                                    |                                            |                               |                                  |            |                                    | X         |
| 3. Employment Service.....                                                                 |                                            |                               |                                  |            |                                    | X         |
| 4. Federal unemployment benefits<br>and allowances.....                                    | X                                          |                               |                                  |            |                                    |           |
| 5. Unemployment insurance<br>benefits and administration.....                              | X                                          |                               |                                  |            |                                    |           |
| From the Department of Agriculture:                                                        |                                            |                               |                                  |            |                                    |           |
| 1. Economic Research Service<br>(human resources).....                                     |                                            |                               |                                  |            |                                    | RD        |
| 2. Agriculture Research<br>Service (human nutrition and<br>consumer research program)..... |                                            |                               |                                  |            |                                    | RD        |

## Key for capacity building

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## FUNCTIONAL CLASSIFICATION OF NEW PROGRAMS

| Program                                                     | Financial Assistance for Individuals | Special Revenue Sharing | National Capacity Building | Regulation | Direct Provision of Services | Eliminate |
|-------------------------------------------------------------|--------------------------------------|-------------------------|----------------------------|------------|------------------------------|-----------|
| From the Department of Agriculture: (cont)                  |                                      |                         |                            |            |                              |           |
| 3. Food and Nutrition Service:                              |                                      |                         |                            |            |                              |           |
| (a) School lunch.....                                       | X                                    |                         |                            |            |                              |           |
| (b) Food stamps.....                                        | X                                    |                         |                            |            |                              |           |
| (c) Meat and poultry inspection.....                        |                                      |                         |                            | X          |                              |           |
| (d) Egg products inspection.....                            |                                      |                         |                            | X          |                              |           |
| Railroad Retirement Board.....                              |                                      |                         |                            |            |                              |           |
| From the Department of Housing and Urban Development:       |                                      |                         |                            |            |                              |           |
| College housing:                                            |                                      |                         |                            |            |                              |           |
| 1. Grants and loans.....                                    |                                      |                         |                            |            |                              | X         |
| 2. Loan guarantees.....                                     |                                      |                         | MSD                        |            |                              |           |
| From the Department of Commerce:                            |                                      |                         |                            |            |                              |           |
| Product safety program of National Bureau of Standards..... |                                      |                         |                            | X          |                              |           |

## Key for capacity building

RD - Research and development; MSD - Market and service development;  
 M - Specialized manpower development; D - Data systems and statistics

THE NEED FOR REFORMING HEW PROGRAMS

|                                                                                        | 1961  | 1969   | 1974            | 1974<br>Compared to<br>1973 |
|----------------------------------------------------------------------------------------|-------|--------|-----------------|-----------------------------|
| Number of HEW Programs.....                                                            | 106   | 250    | 307             | +22                         |
| Funding Authorizations, Budgets and Appropriations                                     |       |        |                 |                             |
| -- Authorizations (in billions).....                                                   | \$ .9 | \$10.3 | \$20.4          | +\$3.2                      |
| versus                                                                                 |       |        |                 |                             |
| -- Appropriations (in billions).....                                                   | \$ .8 | \$ 5.1 | \$ 7.4          | +\$ .2                      |
| -- Share of budget subject to control<br>by Executive.....                             | 12%   | 16%    | 6%              | -4%                         |
| -----                                                                                  |       |        |                 |                             |
| Programs and Budgets Serve Very Few in<br>Need of Same Services                        |       |        | Current<br>Cost | Full<br>Coverage            |
| -- What it would cost to extend<br>today's HEW services to all<br>in need.....         |       |        | \$9 billion     | \$250 billion               |
| Programs and Budgets Overlap and<br>Duplicate                                          |       |        |                 |                             |
| -- Number of instances in which HEW<br>overlaps other departments and<br>agencies..... |       |        | 36              |                             |
| -- Number of instances in which HEW<br>programs overlap with each other.....           |       |        | 54              |                             |

PRINCIPAL OBJECTIVES OF HEW REFORM

New Federalism

- Power to the people in the form of buying power and opportunities for choice through complementary programs in Income Maintenance, Health Insurance and Student Assistance
- Decentralization of planning and decision-making to State and local governments through Education, Social Services, and Health Revenue Sharing
- Increased reliance on private sector through limited and consolidated market development authorities rather than service subsidies
- Restricted and well-defined Federal role in service provision aimed at building capacity of State and local governments and other private and public institutions to provide services

Simplification of relationships among citizens, Federal, State, and local governments--making government understandable and credible

Insuring equality of access to all government programs at all levels

Making HEW more manageable by reducing the number of programs and rationalizing Federal role

OVERVIEW OF THE REFORMS

Aid to Families and Individuals

- . Comprehensive Income Maintenance Program, consisting of a Federalized welfare program specifying minimum benefits and work requirements; job opportunities and related services; and Social Security
- . Health insurance--universal maximum liability coverage
- . Student Assistance--all post-secondary education

Special Revenue Sharing

- . Health
- . Education
- . Social Services

Capacity Building

- . Research and Development
- . Market and Services Development
- . Special Manpower Development

Regulation

- . Limited direct regulation of private markets--FDA
- . Limited indirect regulation--conditions on receipt of Federal funds
- . Enforcement of civil rights provisions of HEW programs

COMPREHENSIVE INCOME MAINTENANCE PROGRAM

Three Types of Support

. Income Assistance . Jobs and related services . Social Insurance

Proposed Reform Integrates Income Assistance with  
an Employment Policy for the Low Income Population

- . Provides for Basic Federal Benefit Levels
  - \$2,700 for a family of four in FY 1976
  - Implicit marginal tax rate of 50%
- . Has a Tougher Work Requirement than H.R. 1
  - No welfare benefits paid to anyone considered to be available for work
  - Heads of single-parent families initially defined as "available" only if all children are at least 15 years old; age cutoff lowered as ability to create job opportunities increases
  - No direct costly Federal day care program
- . Has a More Credible Set of Manpower Policies
  - Supplements income of working poor families
  - Strong incentives to work in regular labor market, including employer tax credit
  - Work opportunities in public sector for "availables"
- . Results in Appropriate Division of Federal and State Responsibilities
  - Federal Government ensures basic minimum assistance levels over time across country without disrupting State labor markets
  - State can supplement according to local priorities

No Major Reform of Social Insurance



#### MAIN FEATURES OF PROPOSAL

##### HEALTH INSURANCE

- . Provides maximum liability coverage for all Americans--Government would insure that personal health expenses would not exceed a maximum level based on family income
- . Covers most medical expenses, including mental health
- . Low maximum liability levels for the poor, but some cost sharing for everyone
- . A National board to regulate utilization
- . Role for private insurance companies:
  - Sell supplementary insurance coverage
  - Act as fiscal intermediaries or underwriters of MLI coverage
- . Financed through general revenues but Medicare payroll tax and income tax deduction for health expenses and health insurance would be discontinued
- Would require more general revenues but would probably cost little more than current and planned Federal health financing programs

#### EFFECTS

- . Insures against real risks rather than expenses that people could be expected to budget for
- . Clarifies health insurance options for the consumer
- . Simplifies Federal support for health financing and services--replaces Medicare, Medicaid, NHIPA, and health service delivery programs
- . Separates health insurance coverage and its financing from employment status--no burden on employers

#### STUDENT ASSISTANCE

Three National programs would give students buying power in the education market place:

- . Basic opportunity grants for low income students
- . Guaranteed unsubsidized loans
- . State scholarship incentive grants

#### Key Features

- . Grant funds would be concentrated on low income students early in their college years
- . Loans would be subject to a premium-financed program of insurance against risks of financial inability to repay loans
- . States would be provided incentives to switch their higher education funds from institutional support to student support

#### Effects

- . Gives low income students access to higher education
- . Creates an equitable capital market for personal investment in higher education
- . Bolsters support for private higher education institutions
- . Eliminates most higher education institutional aid programs

HEALTH SPECIAL REVENUE SHARING

- . Combines several existing State formula and project grant programs into a single grant to be used for:
  - Public Health Activities, including VD control, drug abuse, and alcoholism
  - Medical Social Services, such as health education, counselling, and outreach
- . No special earmarks or pass-through requirements
- . Formula is based on general population, financial need, and incidence of public health problems
- . Approximate funding level of \$500 million in FY 74

EDUCATION SPECIAL REVENUE SHARING

- . Consolidates more than 35 existing programs in Elementary and Secondary Education
- . Contains five earmarks
  - Education for the disadvantaged (EEOA)
  - Handicapped
  - Vocational/Occupational education
  - SAVA A Impact Aid
  - Support Services
- . Retains comparability requirements for the disadvantaged
- . Approximate funding level of \$4 billion in FY 75

SOCIAL SERVICES SPECIAL REVENUE SHARING

- . Combines six major social service programs
  - Existing formula grant programs in Social Services, Child Welfare, Vocational Rehabilitation, Developmental Disabilities, and Programs for the Aging
  - Head Start Service Programs
- . Each State must maintain their current level of effort.
- . Funds distributed to Governors on basis of poverty population across States; 90% of funds must be distributed among sub-state areas on same basis.
- . Contains two sets of earmarks:
  - Minimum percentages for the aged, children and families, and disabled
  - 90% of the aggregate must go to the poor
- . Administrative requirements:
  - Income tested fee schedule for services that can be priced
  - Joint State-local planning process
- . Approximate funding level of \$3.2 billion in FY 1974

MARKET AND SERVICES DEVELOPMENT

Focus on service delivery and supply problems not corrected by financial assistance:

- . Strictly time-limited interventions on priority problems
- . No service subsidies
- . Principally for innovation and start-up costs

Five consolidated authorities:

- . Higher Education--institutional reforms
- . Elementary and Secondary--dissemination of new learning techniques
- . Health--HMO's and other delivery mechanisms
- . Social Services--Markets for child care and special needs of elderly
- . Service integration cutting across functional lines

One construction authority:

- . Loan guarantee program to overcome capital market barriers for public facilities construction in health, education, and welfare

SPECIAL MANPOWER DEVELOPMENT

SOLVES THREE BASIC PROBLEMS

- . Inadequate recruitment in certain professions, including limited minority participation
- . Training institution bottlenecks
- . Unequal and inappropriate distribution of output

NEW CONCEPT

- . Single manpower authorities in Health, Education, and Social Services with two components in each:

Student Assistance

- . Closely linked to general student aid package
  - Extends loan guarantee
  - Extends Basic Opportunity Grant for selected disciplines
  - Provides loan forgiveness for work in underserved areas

Institutional Aid

- . Single authority, combining capitation and special project support to
  - Maintain needed supply of training opportunities
  - Defray a portion of expensive training costs
  - Reform training process



LEGISLATION REQUIRED TO SUPPORT NEW REFORM

A. Assistance to Individuals

- . Welfare Reform
- . Health Insurance
- . Student Assistance
- Basic opportunity grants
- Loan guarantee
- State scholarship incentive grants

B. Special Revenue Sharing

- . Health
- . Elementary and Secondary Education
- . Social Services

Research and Development

- . Five consolidated authorities
  - Mental health
  - Health services
  - Education
  - Social services
  - Income maintenance
- . Biomedical research

C. Capacity Building

Special Manpower Development

- . Three authorities: Health, Education and Social Services
  - Student assistance
  - Institutional assistance

Market and Services Development

- . Five consolidated authorities
  - Higher education
  - Elementary and secondary
  - Health
  - Social services
  - Service integration
- . Construction
- Loan guarantee program

COMPARATIVE BUDGET ANALYSIS  
BUDGET TOTALS  
(Dollars in millions)

|                                                          | 1974                |               | 1976                |               | 1978                |               |
|----------------------------------------------------------|---------------------|---------------|---------------------|---------------|---------------------|---------------|
|                                                          | Current<br>Programs | HEW<br>Reform | Current<br>Programs | HEW<br>Reform | Current<br>Programs | HEW<br>Reform |
| HEW Programs (RA):                                       |                     |               |                     |               |                     |               |
| Assistance to Individuals.....                           | 90,710              | 90,703        | 112,364             | 114,721       | 131,104             | 134,894       |
| (Outlays).....                                           | (84,154)            | (83,924)      | (105,130)           | (112,623)     | (124,036)           | (131,974)     |
| Special Revenue Sharing.....                             | 7,560               | 7,710         | 8,900               | 7,765         | 10,478              | 8,054         |
| Capacity Building and<br>Administration.....             | 5,466               | 4,774         | 6,161               | 4,936         | 6,839               | 5,029         |
| Total HEW Budget Authority....                           | 103,736             | 103,187       | 127,425             | 127,422       | 148,421             | 147,977       |
| Outlays.....                                             | 96,361              | 95,936        | 119,560             | 125,605       | 140,513             | 143,325       |
| Relevant programs in other<br>Federal agencies - outlays | 4,850               | 4,891         | 5,050               | 1,771         | 5,250               | 1,775         |
| Revenue Offset.....                                      | ---                 | ---           | ---                 | -7,000        | ---                 | -8,400        |
| Net Effect on Federal Budget.....                        | 101,221             | 100,827       | 124,610             | 120,376       | 145,763             | 136,700       |

COMPARATIVE BUDGET ANALYSIS  
ASSISTANCE TO INDIVIDUALS  
(Outlays in millions)

|                                    | 1974             |            | 1976             |            | 1978             |            |
|------------------------------------|------------------|------------|------------------|------------|------------------|------------|
|                                    | Current Programs | HEW Reform | Current Programs | HEW Reform | Current Programs | HEW Reform |
| <u>Assistance to Individuals</u>   |                  |            |                  |            |                  |            |
| Income Maintenance:                |                  |            |                  |            |                  |            |
| HEW Federal Funds.....             | 10,122           | 10,097     | 12,096           | 15,694     | 13,593           | 16,059     |
| HEW Trust Funds.....               | 54,474           | 54,349     | 62,653           | 62,103     | 72,436           | 71,736     |
| Other Federal Agencies.....        | 4,850            | 4,850      | 5,050            | 1,700      | 5,250            | 1,700      |
| Subtotal.....                      | 69,446           | 69,296     | 79,799           | 79,497     | 91,279           | 89,495     |
| Health Insurance and Services:     |                  |            |                  |            |                  |            |
| Medicaid.....                      | 4,809            | 4,809      | 7,106            | ---        | 9,206            | ---        |
| Medicare.....                      | 12,524           | 12,524     | 16,520           | 2,450      | 21,200           | ---        |
| NHIPA.....                         | ---              | ---        | 4,000            | ---        | 4,666            | ---        |
| Maximum Liability Health Insurance | ---              | ---        | ---              | 30,000     | ---              | 40,800     |
| Health Services.....               | 834              | 829        | 950              | 627        | 1,009            | 294        |
| Revenue Offset.....                | ---              | ---        | ---              | -7,000     | ---              | -8,400     |
| Subtotal.....                      | 18,167           | 18,162     | 28,576           | 26,077     | 36,081           | 32,694     |
| Higher Education Assistance:       |                  |            |                  |            |                  |            |
| Student Aid .....                  | 1,168            | 1,203      | 1,564            | 1,652      | 1,672            | 1,385      |
| Institutional Aid .....            | 223              | 113        | 241              | 97         | 254              | ---        |
| Subtotal                           | 1,391            | 1,316      | 1,805            | 1,749      | 1,926            | 1,385      |
| Net Effect on Federal Budget.....  | 89,004           | 88,774     | 110,180          | 107,323    | 129,286          | 123,574    |

\*Assumes expansion of present NHIPA proposal to cover: (1) singles and childless under FHIP;  
(2) more comprehensive FHIP benefit package; (3) Federal funding of a portion of the "pool" subsidies under NHISA.

ALTERNATIVE 1974 HEW BUDGETS  
(Budget Authority in Millions)

| NEW Programs                              | Current Programs |                | Reform Proposal |                |
|-------------------------------------------|------------------|----------------|-----------------|----------------|
|                                           | HEW<br>Budget    | OMB<br>Ceiling | HEW<br>Budget   | OMB<br>Ceiling |
| Assistance to individuals:                |                  |                |                 |                |
| Income maintenance.....                   | 6,261            | 66,391         | 67,211          | 66,366         |
| Health insurance and services.....        | 1,709            | 21,709         | 21,704          | 21,704         |
| Higher education.....                     | 1,740            | 1,695          | 1,788           | 1,788          |
| Subtotal, BA.....                         | 90,710           | 89,795         | 90,703          | 89,856         |
| (Outlays).....                            | (84,154)         | (82,400)       | (83,924)        | (82,379)       |
| Special Revenue Sharing:                  |                  |                |                 |                |
| Health.....                               | 504              | 504            | 504             | 504            |
| Education.....                            | 3,070            | 3,070          | 3,070           | 2,897          |
| Social Services.....                      | 3,152            | 3,152          | 3,152           | 2,926          |
| Categorical Grants.....                   | 984              | 984            | 984             | 500            |
| Subtotal.....                             | 7,560            | 6,677          | 7,710           | 6,827          |
| Capital Building:                         |                  |                |                 |                |
| Market and Services Development.....      | 1,283            | 1,168          | 931             | 901            |
| Research and Development.....             | 1,973            | 1,928          | 1,973           | 1,928          |
| Special Manpower Development.....         | 1,000            | 1,000          | 775             | 775            |
| Regulation, Administration and Other..... | 1,210            | 1,153          | 1,095           | 1,056          |
| Subtotal.....                             | 5,466            | 5,249          | 4,774           | 4,660          |
| Total:                                    | 103,736          | 101,721        | 103,187         | 101,345        |
| Budget Authority.....                     |                  |                |                 |                |

COMPARATIVE BUDGET ANALYSIS  
SPECIAL REVENUE SHARING AND CAPACITY BUILDING  
(Budget Authority in Millions)

|                                               | 1974                |               | 1976                |               | 1978                |               |
|-----------------------------------------------|---------------------|---------------|---------------------|---------------|---------------------|---------------|
|                                               | Current<br>Programs | HEW<br>Reform | Current<br>Programs | HEW<br>Reform | Current<br>Programs | HEW<br>Reform |
| <u>Special Revenue Sharing</u>                |                     |               |                     |               |                     |               |
| Health.....                                   | ---                 | 504           | ---                 | 536           | ---                 | 569           |
| Education.....                                | ---                 | 3,070         | ---                 | 4,077         | ---                 | 4,333         |
| Social Services.....                          | ---                 | 3,152         | ---                 | 3,152         | ---                 | 3,152         |
| Categorical Grants.....                       | 7,560               | 984           | 8,900               | ---           | 10,478              | ---           |
| Subtotal.....                                 | 7,560               | 7,710         | 8,900               | 7,765         | 10,478              | 8,054         |
| <u>Capacity Building:</u>                     |                     |               |                     |               |                     |               |
| Market/Services Development.                  | 1,283               | 931           | 1,510               | 931           | 1,777               | 881           |
| Research and Development.....                 | 1,973               | 1,973         | 2,301               | 2,301         | 2,565               | 2,565         |
| Special Manpower Development.                 | 1,000               | 775           | 1,063               | 600           | 1,129               | 445           |
| Regulation, Administration,<br>and Other..... | 1,210               | 1,095         | 1,287               | 1,104         | 1,368               | 1,138         |
| Subtotal.....                                 | 5,466               | 4,774         | 6,161               | 4,936         | 6,839               | 5,029         |
| <u>Transfers to Other Federal Agencies</u>    |                     |               |                     |               |                     |               |
|                                               | ---                 | 70            | ---                 | 73            | ---                 | 76            |
| <u>Total:</u>                                 |                     |               |                     |               |                     |               |
| Budget Authority.....                         | 13,026              | 12,554        | 15,061              | 12,704        | 17,317              | 13,159        |
| Outlays.....                                  | 12,207              | 12,053        | 14,430              | 13,053        | 16,477              | 13,126        |